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Hospital Reports.

ST. GEORGE'S HOSPITAL.

ACUTE RHEUMATISM: PERICARDITIS: PLEUROPNEUMONIA: DIFFUSION OF FIBRINE AMONGST THE MUSCLES OF THE NECK.

Under the care of H. BENCE JONES, M.D.Cantab.: with Remarks by G. GODDARD ROGERS, M.D., Medical Registrar to the Hospital.

C. H., aged 15, a baker's apprentice, was admitted on November 19th, 1856, with acute rheumatism. Six years ago he had a similar attack, and was laid aside nearly twelve months. The present attack commenced four days before admission. He had been riding in a cart during a keen wind; on going to bed, he felt slight pain in his limbs, and found the next morning that he was unable to walk.

The left knee and ankle were swollen, red, and painful; the right knee had been affected, but got better before he came under our notice. He perspired profusely, and suffered most pain at night. The tongue was coated with brown fur; and he had severe constant headache. At the base of the heart a murmur was heard with the first sound; a doubtful systolic murmur was distinguishable at the apex. The heart's action was feeble; and the sounds, both at base and apex, were indistinct. The urine was copious, and of a deep colour; free from lithates or albumen. He was ordered the usual saline mixture, with ten grains of nitrate of potass every six hours; the bowels to be opened by senna; and a morphia draught to be taken at bedtime.

November 20th. He had very little sleep. Bowels freely open. He complains much of headache. The right knee and ankle have again become inflamed. There is a decided murmur at the apex to-day. Two grains of calomel and half a grain of opium were ordered to be taken three times a day.

November 22nd. The right wrist and elbow are swollen; the other joints much the same.

November 23rd. The right leg and wrist are better. The left arm is commencing to be painful. Bowels not open since 20th. The urine is quite as deep coloured. Tongue much furred. Pulse 100, and full. Mitral murmur very indistinct. The aperient was repeated.

November 25th. All his symptoms have been much relieved by the free evacuation of the bowels. Tongue cleaning; pulse soft; urine of natural colour. The headache, however, has never entirely left him.

November 27th. Yesterday and to-day he has been complaining very much of his head. He is slightly deaf, and appears drowsy. The joints are quite free from pain. A loud murmur can be heard at the apex of the heart. There is great tenderness all over the sternum. He vomited early this morning.

November 28th. Towards evening he had slight cough. The intercostal spaces were painful. In the afternoon he vomited again, and complained of intense headache. Slight convergent strabismus was noticed. During the night he rambled very much. The murmur at the apex was very faint; there was no friction sound. Coarse moist sounds were heard over the left lung. On the right side the breathing was somewhat exaggerated. There was no dulness anywhere. A blister was put upon the left side; and the saline treatment continued, with calomel and opium, as before.

November 29th. He was constantly moaning and talking in his sleep during the night. His pupils are contracted; there is great photophobia, and very severe headache, which is increased when he attempts to sit up. There is very little cough. Bowels open. Pulse 112, small and weak. Moist sounds are heard at the back of the right lung. He was ordered to take the calomel every four hours. In the afternoon a severe attack of dyspnœa came on.

November 30th. He is very much weaker, and lies in a semi-comatose state; but when roused, answers rationally. A blister was put on the neck. He had dry harsh cough. Throughout the night he had low muttering delirium; and at 8·30 A.M. next day he expired.

The examination was made twenty-nine hours after death.

Both pleural sacs contained abundance of recent fibrine, and the left one a small quantity of turbid fluid. The left lung was congested in one or two places, but nothing more. The right lung, except just at its upper part, was passing into the stage of grey hepatisation. The bronchi were very vascular, and contained light yellow fibrinous casts. The bronchial glands were much enlarged. The pericardium, especially towards the base of the heart, was very thick; and, together with the fasciæ at the upper part of the thorax, was consolidated by much recent yellow fibrine. The pleural lining of the upper and posterior part of the chest was likewise very much thickened. In the pericardial sac, some turbid fluid and flakes of recent fibrine existed; and there were old adhesions in one or two places at the base of the heart. The walls of the heart were natural; the aortic and mitral valve flaps showed very trifling thickening. There was much recent fibrine between and behind the muscles in front of the larynx; and the various folds and layers of fasciæ in the upper part of the neck were thickened, and occupied by the same deposit. This was the case also with the sheaths of the great vessels, especially on the left side. At quite the lowest part of the neck, the vessels, nerves, fasciæ, and muscles, were blended together by fibrine, which, in one or two places, was softened, and of a yellowish green hue. This fibrinous exudation was also found about the muscles in front of the cervical vertebræ. The left internal jugular vein was rigid, and full of firm coagulated fibrine not undergoing change, and not adherent to its walls. All the abdominal viscera were natural; and the wrist and knee-joints were free from any purulent deposit.

REMARKS. This case affords a good illustration of the well established fact, that pleurisy, and not unfrequently pneumonia, are associated with pericarditis. It also shows that attention may be so fully directed to the heart symptoms, that the above mentioned complications are to a great extent in danger of being overlooked. Or they may progress rapidly, and cause frightful havoc, whilst the signs of their existence are not very evident. The patient C. H. died on the 30th of November. On the 28th, there was no dulness over either lung, but simply exaggerated breathing on the right side. Within two days, therefore, complete hepatisation passing into the third stage must have been established. There was no cough until the night of the 28th, and it was never accompanied by expectoration; whilst the inflammation involving the muscles and their connecting areolar tissue in the neighbourhood of the larynx, and the pressure by fibrine on the phrenic nerve, sufficiently account for the dyspnœa. The headache, drowsiness, and delirium, may be referred in part to the cardiac affection, as an instance of (so-called) metastasis to the brain. But the cerebral symptoms, which accompany rheumatic carditis, generally make their appearance towards the close of the disorder, or when the inflammation is at its highest; and from the first day of this lad's admission into the hospital headache was a prominent feature. Rheumatic inflammation of the fasciæ at the root of the neck being excited, the mischief spread rapidly to the surrounding parts. The sheaths of the great vessels thus participating, and becoming thickened, hindered the free passage of blood to and from the brain. That venous congestion was thus caused, was shown by the aggravation of headache when our patient raised himself. The muscles of the neck were then brought more into play, and their contraction increased still farther the compression around the blood-vessels. As to the respective clearness of the murmurs at the base and apex of the heart, the former was all along clear and distinct; the latter occasionally doubtful, and often very faint. I therefore infer that anæmia had much to do with the produc-

tion of the first; and probably before the rheumatic attack came on, and when he was in good health, it was quite as indistinct as the systolic mitral murmur. The amount of valvular lesion was so very slight, that it would have been no wonder if the natural sounds had been heard throughout. With respect to pericardial friction sound, none was discovered. There was probably extensive pericarditis during his former attack of rheumatic fever, but only a very limited affection of the membrane this time; and that not until a few hours before death.

Original Communications.

ON DISEASE OF THE SUPRARENAL CAPSULES.

By S. J. JEAFFRESON, M.D., F.R.C.P., Physician to the Warneford and Leamington Hospital.

[*Read before the Birmingham and Midland Counties Branch, December 11th, 1856.*]

THE recent researches, and the able and elegant work of Dr. Addison, on *Disease of the Suprarenal Capsules*, have latterly attracted so much attention on the part of the medical profession, that I hope I may be excused the liberty of drawing attention to three cases of this malady which have fallen under my own observation. The two former may perhaps derive some additional interest from the fact, that they occurred prior to the date of Dr. Addison's discovery of the connexion between this form of disease and certain discoloration of the skin. The connexion between these conditions was a fact so remarkable, that it drew my attention at the time, and caused me to remark it to several of my professional brethren; but as I failed to obtain any confirmatory evidence of the connexion of these phenomena, by seeing or hearing of other similar cases, I quite lost sight of it, till Dr. Addison published his views.

Let me, however, be distinctly understood as not in any way wishing to detract from the merit of Dr. Addison in having first worked out and made public this curious fact. A large hospital, especially in London, gives to the medical staff not only a great numerical advantage of cases, but all the assistance implied by a numerous staff of intelligent colleagues, assiduously engaged in the work of learning, for the best of reasons that they are obliged to teach, and all deriving the greatest advantage from the division of labour implied by the assistance of their more advanced pupils. The want of these advantages may probably have precluded me from following up these cases; and the want of them must also be kindly taken by you as an excuse for many of those defects in the following reports, which are almost necessarily incidental to one who, in the midst of all his other pursuits, has to do this kind of work single-handed.

Except when stated to the contrary, I shall briefly relate the following cases in the words noted down at the time of their occurrence.

CASE I. Thomas Wilkins, aged forty, a labourer, residing in Woodhouse Street, Warwick, was admitted a patient of the Warwick Dispensary, on the 28th August, 1849. He stated that he had not been well since the previous Michaelmas, when he caught cold whilst working at Leamington, attended by violent pain of the lower right chest, followed by jaundice. The pulse was 88, feeble; the conjunctivæ were not then yellow, but the skin was; bowels regular; motions yellow. He often vomited. He was so cold—"feet like death often". The following medicine was ordered.

℞ Magnesiæ sulphatis ℥ix; potassæ nitratis ℥iii; potassæ chloratis ℥ii; spiritûs ætheris nitrici, spiritûs juniperi compositi, ää ℥i; aquæ menthæ piperitæ ad ℥xviii. M. Fiat mistura, cujus sumatur ℥i ter die.

Sept. 4th. I find it noted that I could discover no enlargement of liver; that his food was frequently vomited, and that he "had lost much flesh". He was now ordered:

℞ Potassii iodidi gr. xxxvi; liquoris potassæ ℥iii; tincturæ calumbæ ℥ss; inf. aurantii compositi ad ℥xii. M. Fiat mistura cujus sumatur ℥i bis die.

Sumat pilulæ hydrargyri chloridi compositi gr. v omni nocte.

Applicetur emplastrum cantharidis epigastrio.

The vivid impression produced on my mind by the peculiarity of Wilkins' complexion, is evinced by the fact that at his visit on September 11th, he brought his daughter with him to show me her complexion, which, he said, "was the complexion of his family, and such as his own was formerly".

The medicines were continued, and the blisters repeated.

Sept. 18th. The complexion was more bright yellow. He heaved, but did not vomit, The motions were lighter and yellow. The mixture and pills were repeated.

Wilkins had been long on the parish, and the parish surgeon stated that he could not longer afford him any extra allowance, in consequence of his inability to pronounce him to be labouring under any specific disease. Under these circumstances, I procured him a hospital ticket, and admitted him an in-patient of the Leamington Hospital on the 26th Sept. 1849. He then had tenderness in the region of the duodenum and the two dorsal vertebræ opposite this point, on firm pressure. He was evidently emaciated, but less so in the abdomen than in other parts; which, indeed, presented some degree of general fulness below the epigastric region. Pulse and heart's action feeble; tongue white; bowels torpid; urine free and pale; conjunctivæ quite clear. The skin was universally of dark leaden hue, a colour something between jaundice and *morbus cæruleus*. The alvine evacuations were reported to be natural in colour. From the first sight of this man at the Dispensary, I thought unfavourably of his case; although, whilst in the Dispensary and subsequently in the Hospital, repeated most careful examinations elicited no evidence of organic disease of his liver, lungs, heart, or other organs. Besides debility, there was a depressed heavy manner about the man, which I did not consider natural to him. He was not, however, despondent, and showed great gratitude for all that was done for him.

His treatment whilst in the Hospital consisted of a blister over the tender vertebræ, nitro-muriatic acid with orange peel, and common non-mercurial aperient pills.

No appreciable change occurred, except that he expressed himself as feeling rather better, which was perhaps due to the nursing, temperature, and improved diet of the Hospital. About four days before his death, whilst holding up the clothes of another patient for me to auscult his chest, Wilkins almost fainted. I made him lie down on his bed, and examined him whilst so faint, without eliciting any evidence of cardiac or other disease.

On the night of the 17th October, having had some green vomiting in the day, and complained much of headache, he went to bed much as usual. About midnight he got out of bed, and was observed by the other patients staggering towards the fire-place: they reached him just in time to save his falling, and called the nurse and house-surgeon, who found him insensible, with stertorous breathing, slight convulsions, fixed and dilated pupils, cold extremities, and almost imperceptible pulse. He died two hours after he got out of bed.

THE POST MORTEM EXAMINATION was made on October 19th, by Mr. Male, Mr. Birt, and myself, about thirty hours after death. The body was less emaciated than I expected to find it. The lungs were pale, healthy, and crepitant. The heart was perfectly healthy in every respect; it contained many fibrinous clots in almost all, if not in all, its cavities; many of them were quite of a yellow colour, and very firm. The large vessels were carefully traced, but presented no evidence of disease. The liver was rather full and darkish coloured, but healthy in structure. The gall-bladder contained healthy bile. The mucous surface of the stomach was much congested in patches; the membrane was polished, firm, and natural. The duodenum was healthy. The other bowels, only examined externally, afforded no suspicion of disease. The muscles and other tissues generally, especially the fatty tissues, showed a deepish yellow stain. The kidneys were healthy; but in the left suprarenal capsule was contained an encysted tumour, apparently of the scrofulous character; its walls were hard and almost gristly and cartilaginous, its contents in various degrees of softening, from fluid pus to cheesy matter. This was the only mark of structural change we could discover in the body. The brain, though most carefully examined, afforded no morbid appearance. In its colour it was natural, being almost the only part which was not tinged with any yellow stain. The stomach contained some grumous greenish fluid like that vomited.

CASE II. On the 23rd of November, 1849, I was called upon by my friend, Mr. Thomas Chavasse, to see Mr. T., a gentleman of sixty-three years of age. Our patient was perfectly comatose: a condition which I believe had crept on during the last twenty-four hours, and appeared to me to be dependent upon cerebral effusion. Blistering and other remedies entirely relieved this condition of the brain, and he was the next day in the most perfect command of his mental faculties, and

enabled to attend to business, and to converse freely and most intelligently.

Almost the only complaint Mr. T. had himself made was of pain of the right shoulder, where, however, no evidence of disease could be discovered. He had been feeble, had lost some flesh, and had experienced occasional vomiting after his meals. He had stated his present deranged state of health to be of about one year's duration; and it was attributed, both by himself and his friends, to great anxiety of mind in consequence of losses and responsibilities in connection with some trustee affairs. His complexion, as respected the face, was very dark, somewhat like that of Thomas Wilkins (Case I). This was not the case in the body or limbs, which were sallowish. The conjunctivæ were clear.

November 24th. The pulse was the same as yesterday—a mere thread and perfectly powerless. There was still no perceptible impulse of the heart; but its sounds, though feeble, were distinct, and without bruit of any kind. His mind was perfectly clear and distinct, even on testing him by a prolonged conversation. He made no complaint of pain except of the right shoulder, and that was less than usual. He had had a fair allowance of sleep. There was no œdema anywhere. On raising him up to examine his chest posteriorly, he soon became faint, and was obliged to be laid down again. It is not stated, though I remember the fact, that the præcordial dulness was much increased in extent and intensity, and that I concluded that Mr. T. must be labouring under hydrops pericardii, as well as his other maladies.

November 25th. Mr. T. died in the evening, apparently from simple exhaustion.

NECROPSY, thirty hours after death, made by Mr. Birt, Dr. Goode, and myself. The body was less emaciated than might have been expected. The discoloration above described was pretty general. On endeavouring to remove the skull-cap, when sawn through, the adhesion of the dura mater was so universal and exceedingly firm, that it was impossible to get the skull-cap off, and we were obliged to remove the entire brain from its base, cutting through the medulla oblongata. The dura mater did not appear much altered in character; the arachnoid was very generally milky, opaque, and thickened, and there must have been very considerable subarachnoid effusion from the quantity of fluid which escaped during the removal of the brain. The substance of the brain did not present any very remarkable appearance. The origin of the eighth pair of nerves seemed to be by finer and more compressed filaments at its root than generally observed; the medulla oblongata also appeared somewhat small and contracted, and the corpora olivaria, pyramidalia, and restiformia were less distinctly marked than usual. The lateral ventricles had been apparently more distended with fluid than natural. On opening the thorax there were considerable old adhesions, most especially on the right side. On reaching the heart we were much puzzled to believe that it could be that organ, for in its position *in situ* it looked more like a bag of fat invested by a thin semi-transparent membrane; this deposition of fat was placed between the pericardia, very firmly and universally adherent to the reflected, less firmly and generally to the true pericardium. The firmness of its adhesion to the true pericardium differed considerably in different parts, and there was also some little fluid in the pericardial cavity. The thickness of this deposit of fat varied from the eighth to upwards of a quarter of an inch. The liver, not amiss in size or structure, presented one puckered, milky coloured cicatrix on its upper surface. The kidneys were flabby and rather elongated; in one of the suprarenal capsules was found a tumour.

I regret to say that my notes of this case go no further. The tumour was handed over either to Dr. Goode or Mr. Birt for microscopic examination, and unfortunately no notes of this examination are on record. My recollection of the case is, however, sufficiently accurate to enable me to state that the tumour was of the size of a large French walnut, and that its section presented cysts in various degrees of softening, just as in the case of Wilkins. In these details I am borne out by Dr. Goode and Mr. Birt.

In the following case, which cannot, I think, fail to be recognised as one of disease of the suprarenal capsules, I am sorry to say that no *post mortem* examination could be obtained, although every effort was made to get permission.

CASE III. Mr. W. R., aged 39, patient of Messrs. Bodington, of Kenilworth, called on me 5th August, 1856. He stated that he had suffered most of the previous winter from tic douloureux, coming on and leaving off suddenly several times in the day, but not during the night—the paroxysms usually lasting from half to three quarters of an hour, affecting the right side of the face, and shooting down to the right breast. On the 30th April he had a tooth drawn on this side, which completely cured the tic-douloureux; but since this period his general health had given way—"has lost flesh; has no appetite; has nausea and occasional vomiting; no headache." The tongue was loaded posteriorly, dryish; the tip and edge being reddish. He had occasionally slight hæmatemesis. His complexion was very sallow, but had been very yellow. The bowels were sluggish; the urine free, clear, too much in quantity.

I considered the case to be one of hepatic derangement, with neuralgia and anæmia, cases by no means uncommon, and prescribed the following:

℞ Emplastri cantharidis partem i; emplastri picis compositi partes v. M. Fiat emplastrum quatuor pollices longum et sex latum, epigastrio applicandum.

℞ Calomelanos gr. i; extracti aloes aquosi gr. iii. M. Fiat pilula alternis noctibus sumenda.

℞ Quinæ disulphatis gr. ii; extracti anthemidis gr. i. M. Fiat pilula bis die sumenda cum haustu infrà præscripto.

℞ Acidi nitrici diluti, acidi hydrochlorici diluti, ää ♏x; tincturæ aurantii ʒss; acidi hydrocyanici (Scheel.) ♏ii; liquoris taraxaci ʒi; infusi aurantii compositi ʒviss. M.

On his next visit (Aug. 12th), I felt convinced that his case was one of disease of the suprarenal capsules, and wrote to Messrs. Bodington to that effect. I was struck by his amazing change for the worse, which could not be accounted for at all by the treatment; and I commenced my notes by "very bad". He had great sickness with yellow and green vomit many days during the week; no appetite; great debility. The opening pills acted nicely; he had taken four. The tongue was decidedly better. He now spoke of pain of a dull kind on and off for some time past in the region of the left kidney. His vomiting occurred once, twice, or thrice a day. It was astonishing how much worn he looked in so short a time, and how much more he was enfeebled. His complexion, even to his hands, was bronzed, and his nails stood out white in contrast. The conjunctivæ were of a dingy leaden yellowish tint. The plaister was kept on four days, and only slightly blistered him. I ordered:

℞ Sodæ sesquicarbonatis ʒij; ammoniæ carbonatis ʒj; potassæ chloratis ʒss; tincturæ aurantii ʒvj; aquæ ℥viii. M. Fiat mistura cujus sumatur pars sexta ter die cum acidi citrici ℈i.

℞ Extracti aloes aquosi gr. iss; extracti hyoscyami gr. iss; M. Fiat pilula pro re natâ sumenda.

August 14th. His wife reported to me that he vomited immediately after the first dose of the mixture to-day, and also yesterday, but not after the others. But he had also been sick after several things he had taken—tea especially. He had, however, never been sick whilst in bed; but only whilst sitting up.

No change marked the future stages of this case, except that of most rapid exhaustion of the vital powers. Intellect was retained to within the last few hours of his life, and he died on the morning of the 20th, without convulsions.

In the former two cases I have no notes of any examination of the urine, but I retain a vivid recollection in both cases, and especially in that of Wilkins, of an examination of the urine without any morbid trace. In the latter case repeated examinations of the urine failed to elicit any morbid condition, either in its specific gravity or as examined by heat, nitric acid, or the microscope.

The former two of these cases derive considerable interest from their accurate correspondence with the description of disease of the suprarenal capsules given by Dr. Addison and others. They were observed long before his views were published, and therefore no colouring can have been given to them, derived from any preconceived views: this, I think, adds much to their concurrent value as establishing Dr. Addison's views. It will be remarked of both these cases that the conjunctivæ were reported to be clear, and I suspect that this is an important distinguishing feature between the discoloration from diseased renal capsules and hepatic disease; for, so variable are the shades of jaundice, that I much doubt whether the eye alone would be competent to detect the difference between some of its forms and the disease in question. I think we can hardly doubt that the third case, that of Mr. R., was also one of disease of the suprarenal capsules; and in this we have an exceptional condition of the conjunctivæ, which are described as being of a "dingy, leaden, yellowish tint." But in the absence of any *post mortem* examination we are not competent

to say that this case was not complicated with some hepatic affection, as I suspected on his first visit to me—a suspicion somewhat confirmed by his own comment on his complexion the first day I saw him, where I note "his complexion is very sallow, but has been very yellow," the latter half of the sentence having been supplied by himself and his wife.

It will be observed that all these cases are males, the ages 40, 63, and 39; the deaths occur in the autumnal season, viz., latter end of August, October, and November. In all three vomiting is a well marked symptom. Two of them are accompanied by well marked neuralgia, in that of Mr. T. of the shoulder, in that of Mr. R. by tic-douloureux of the face. May the pain that Wilkins experienced in the commencement of his illness have been pleurodynia? The absence of any trace of previous inflammatory mischief about the chest and liver, lends some countenance to the idea. In two out of the three cases the urine is especially described as copious and clear, another fact much opposed to the ordinary condition of this secretion in hepatic affection.

The peculiar interest in the case of Wilkins is the entire absence, under most careful and minute examination, of any other form of disease whatever; whilst that of Mr. T. is hardly less interesting from its complications.

Having said so much on these cases, I will not venture to make any general remarks upon this disease; and the more so, inasmuch as I have not had the opportunity of consulting the actual work of Dr. Addison, but only extracts from it.

It may fairly be asked, does the general anæmia depend upon the disease of the suprarenal capsules? or, is the local malady but an expression of the constitutional? The case of Wilkins goes, I think, far to affirm the former supposition, and to prove that the local malady is in itself capable of spoiling the vital fluid to the extent of destroying life itself. It is probable that further researches on this interesting subject may lead to the discovery of some important laws respecting the physiological import of not only the suprarenal capsules, but of several other organs, whose use in the animal economy has been hitherto clothed in mystery.

MEDICAL NOTES ON THE MILITIA.

By J. I. Ikin, Esq., Leeds.

No. IV.

HOSPITAL REGULATIONS OF THE PUBLIC SERVICE: WITH REMARKS ON MALINGERING: DESERTION: MILITIA ANECDOTES, ETC.

I stated in my former paper that the regimental surgeon is responsible for the correct keeping of the medical register, which, according to the hospital regulations, must contain a detailed account of *every* case treated, except itch. When the Inspector from the Medical Department visited our hospital, then in the citadel at Hull, he pointed out to me that the register was not complete, as only a portion of the cases was entered at length, whilst every case ought to have been registered as pointed out by the regulations; and he added, that he himself, whilst a regimental surgeon, never omitted fully to transcribe every case, even when he had a large hospital full, as was often the case on the West Indian stations; and that he had sometimes entered sixty or seventy cases in a day. This certainly was most praiseworthy industry; but, on foreign stations, the diseases, such as yellow fever, etc., often assume strange and peculiar types, worthy of record. I at once admitted that the blame, if any, rested upon my shoulders, as I had taken upon myself to direct the assistant-surgeon to discontinue keeping a detailed account of each case, and only to record the most interesting and severe cases, as it seemed to me a needless waste of time and paper to fully record every case of ordinary catarrh, mild febrile attack, or gonorrhœa, as all the cases were regularly entered in the admission and discharge books. This was not considered a satisfactory explanation, and next day I received a long official letter, calling my attention to the omission. Luckily, we had all in order in the hospital, and according to regulation, saving this breach of duty, if it deserves to be so called; so that no fault could be found with the state of the hospital, though we had only a few hours' notice of the Inspector's visit. A remark was, however, made on looking over the diet tables, on the *generous* nature of the diets, the number of extras, beer, wine, etc., which, he said, seemed to be very generally allowed, and were rather inconsistent with active treatment; and that they might be thought expensive at the War Office, and probably lead to some explanation being required. My reply to this remark was, that I found, from experience, in the great majority of cases, reducing young recruits and sick men by long continued "spoon or low diet" was most prejudicial, and considerably retarded their recovery; that I had found that generous diet was economy in the end, and sooner emptied the hospital; and that my monthly sick reports proved how rapidly the men were cured, and the patients sent from hospital fit for duty. I ventured to add, also, that, if the authorities in London could judge better than I could what diet was required by the sick under my charge in Hull, the sooner medical officers were dispensed with the better. No reply was or could be given to this, except that the Medical Department wished to place no obstacle in the way to the efficient treatment of the sick, but the contrary. I must, in justice to the service, here add, that the medical officer has really the power to order what he likes, and what he considers requisite, though at times explanations are required, and his orders must be carried out in regulation fashion. A medical friend of mine had to account for a large consumption of wine and brandy in hospital, and this he succeeded in doing at once by showing the number and malignant nature of cases of fever of a typhoid character he had had to treat. By a somewhat strange coincidence, and to my gratification, within a very few days of our inspection, an altered and improved hospital diet table was issued from the War Office for the use of the service, allowing medical officers to order extras in form of food, besides porter, wine, beer, brandy, etc., with any of the diets, instead of, as heretofore, being restricted to particular diets.

I was also asked if I kept a meteorological table, and registered my observations. My reply was, that I did not; but that, when furnished with barometers, thermometers, weather-vanes, and other suitable hygrometric apparatus, the observations should be made. As, however, I made a practice, with the above trifling exceptions, of rigidly complying with (or directing they should be complied with) every medical regulation of the service, esteeming it my duty to do so, or to resign my appointment, I was at special pains to render my annual report at the end of the year complete, and in accordance with the regulations, as previously described: I therefore filled up the meteorological tables for each month with a transcript from the register kept at the Philosophical Society at Hull, the completeness of which ought to have been satisfactory to the authorities, if they were ever at the trouble of perusing the document at all.

I have now faithfully enumerated the returns and reports required from the regimental surgeon by the War Office and Medical Department; and I may add that, along with these, the correspondence with the purveyor on home service is incessant; and I believe surgeons on foreign service find their communications with the Commissariat no less troublesome.

In concluding this part of my observations, desultory as I fear they will be considered, I would confidently appeal to the authorities themselves, as well as to the profession; and inquire whether the duties of the regimental surgeon are not overlaid with needless forms and bookkeeping; and whether this system of routine must not occupy the time which ought to be given to the strictly professional and more important duties of attending to the sick? Did the system, or did it not, break down at the onset of the late war? and may it not do so again? For fear of breaking the rules of the service, not acting according to regulation, or from not filling some form or requisition, or the document not going through the proper channel, what confusion, neglect, and misery, was the result! The regimental surgeon not having sufficient authority, one officer relying on some other officer, one department on that of another, action at the right time and in the right place become impossible; and clothing, bedding, drugs, and medical comforts, lie useless or rotting in some ship's bottom close at hand. The medical officer should surely be master and responsible in his own department, if the system is to be reformed, and emergencies met at once. Let, then, the authorities consent to simplify their numerous regulations, and subject them to a careful revision. The formation of a medical staff corps, great improvement as it will prove in the management of military hospitals, is not all that is required; the *system itself* should be revised, and conducted more in accordance with the rules that govern every well ordered public or private undertaking, where each officer is supreme in carrying on his own individual department, though responsible to his superior for the result and expenditure. Now that the excitement of the war is subsiding, and attacks on *individuals* in authority or command (often unjustly

made) have ceased, and a calm and dispassionate survey of the working and complicated routine of the various public departments can be taken, it is to be hoped the result will be the accomplishment of improvements and reforms which time and trial prove to be required in all human institutions, not excepting government offices.

I have a few other remarks to introduce, as I forbear to dwell on topics which have unhappily given rise to such painful reflections in the public mind, to serious public inquiries, and to the animadversion of the most powerful portion of the press.

To turn to less serious matters, let me add a word on the preservation of medical comforts, such as wine, spirits, and laudanum. They should be carefully secured, or the consumption in most military hospitals would be amazingly quick and copious. I was unlucky in having in my own regiment (whilst in charge of line regiments, I was more fortunate) two hospital sergeants, each of whom had a morbid taste for tincture of opium as well as for brandy: at last, gratifying their tastes beyond all moderation, they were discovered and punished. One of them, however, became maniacal, and threatened to kill both hospital orderlies and doctors. I found him one night, on making unexpectedly the evening visit, sitting mad drunk in his room, which he had lighted up with a number of candles, in full uniform, a drawn sword in his hand, and his musket, with fixed bayonet, at his side, shouting and defying any one to take or approach him; the orderlies in a state of alarm, and the whole hospital in great excitement. With management and the help of the orderlies, I closed with him, seized his sword and musket, and got the orderlies to knock him down on the bed, and try to hold him there till I obtained a guard to remove him. Whilst I went away with the sword to see the colonel, and procure help, he got free, having defeated both orderlies; so, when I returned with the guard, I again found him flourishing away with another sword. It appeared the sword just obtained was my own, which I had forgotten was left under his charge, and which, in the affray, got damaged; and that the second was his, which he kept hung up in his room, and which I had overlooked. He was secured, and sent to the cells, where he tore to ribbons every article of his dress, and almost smashed the prison door to pieces. On recovering from this attack of drunken mania, I got him discharged as insane, having ascertained he had been so previously; and, as I did not consider him responsible for his actions, he was not severely punished.

My other sergeant, a clever well educated fellow and good accountant, but dreadfully dilatory, was equally given to drink, and had a trick (as we suspected, but never could strictly prove) of diluting the laudanum with water after taking a dose. The source of temptation was removed, and rigidly kept under lock and key; and the threat of getting him reduced to the ranks, if drunkenness or any other evil habit was observed, constantly hung over him, and kept him in something like order; but, finding him such a useful servant, I befriended him as long as I could with any amount of propriety, as the teaching a hospital sergeant his duties is no joke, and entails endless trouble on the surgeon. When the regiment was disembodied, I had sundry bills for spirits supplied to my sergeant, and left unpaid, forwarded to me.

I will here add a few remarks on *desertion*. It appears from official returns (*vide* Roberts), that, in the three branches of the service, artillery, cavalry, and infantry, desertion is by far the most frequent in the latter; and that, out of a force of 43,000 in the United Kingdom, an annual loss of 3,000 men by desertion, takes place in the following proportions; showing that, when pay is highest, desertion is least.

In the Artillery	5	per 1,000
In the Cavalry	8	„
In the Foot Guards	8	„
In the Infantry	55	„

With regard to *branding* deserters with the letter D, I much question the propriety of this punishment in the case of militiamen, as it tends to render a temporary service unpopular; and it is very questionable whether any severe punishment like this, or flogging (now, happily, almost entirely given up), tends to reform military offenders. We had a few of our deserters branded, three or four; and when the first case of branding was ordered by court martial, and confirmed by the General commanding the district, it made a great commotion, as the sentence is read on parade before the whole regiment. From some oversight of the commanding officer of the day, the assistant-surgeon was sent for to brand the deserter on the spot. Luckily, he had not the means of doing it with him, and declined; and the prisoner was removed to the hospital to have it done there. I was not in barracks at the time; but, on going to the hospital next day, I heard what had happened, and at once protested against the employment of a medical officer for such a duty, as the rules of the service no longer require him to brand deserters (though they did formerly), the duty now devolving upon the drum-major, who ought to do it under the superintendence of the medical officer; consequently, this was the case in future, and the assistant was spared such an ignoble duty. Branding is done (not burnt with an instrument or brand, as formerly) with three or four needles tied together, and the letter D is pricked out in the skin under the left arm; a little gunpowder rubbed in, which does better than caustic; in fact, it is the same as tattooing.

In inspecting recruits, I have frequently detected the most ingenious tricks for concealing the letter D, the mark of which is an insurmountable objection to re-entering the service; and, on the other hand, I have detected men malingering, and even wearing a truss, saying that they were ruptured, when no hernia existed, in order to obtain their discharge, or escape hard labour punishment. I once certified a deserter as fit for hard labour and confinement in Weedon Prison; and the medical officer there reported he had been sent with a rupture, and was consequently unfit for hard labour. The governor reported the case to the General of the district. I received from him, through my commanding officer, a severe official communication, and the request of an explanation of my apparent neglect of duty in certifying such a man as fit for hard labour when he had a rupture. I was able to give an explanation, and repeated my own and the assistant-surgeon's unqualified opinion that he had no hernia when sent to Weedon, though he thought proper to wear a truss. We luckily had kept him under observation for a day or two, to be on the safe side, before giving the certificate: in fact, we knew him to be a bad character and malingerer, and he was so entered in the defaulter book. I presume my explanation was thought satisfactory, as I heard no more from the General; but I at once put myself in communication with the surgeon of Weedon Prison, and remonstrated with him for reporting the case without previously communicating with me. To my great satisfaction, in a short time afterwards, he wrote a long explanation, stating that the man had deceived him, and that he now felt convinced that he did not suffer from hernia, but was an accomplished rogue and malingerer, and ought to be punished.

With regard to concealing the letter D, a recruit one day presented himself, a strong likely man for the service, with pieces of plaster stuck on different parts of his body, and one under his left arm. On my asking the reason, he said he had been teazed with boils; but, on my raising the plaster on the above region, I at once detected the mark of D. In another case, the mark was neatly rubbed over with a sort of flesh-coloured paste; but, unfortunately for him, a little bit was loose, and, on applying my finger, "the d——d D", as the man termed it, was discovered, or else he would have passed. I have been deceived in this way, but not often. I have known men to hire false teeth, in order to try and pass the surgeon. One young fellow, by no means bad looking, tried me several times and at different places, both at Leeds Barracks, my own surgery, and at some of the neighbouring towns. The last time, he turned up with false front teeth (his own having been broken by an accident), and I had nearly overlooked them and passed him, but, calling to mind his features, I took him close to the window, and discovered the ingenious trick, and was obliged to refuse him. His plea was, that I had previously said "his only chance to become a soldier was to get some false teeth," and he had done so. He had agreed to pay so much for the loan of the teeth for the day, if rejected; and to purchase them, if he passed. The poor fellow showed such anxiety to serve his Queen and country, that I really think I ought to have passed him.

I may here add another amusing incident in militia life, showing how soon the *esprit de corps militaire* is established. Our regiment had not assembled for the first training above a few days when, one morning, a man applied at the hospital with some dreadful bruises and a black eye. On inquiring how it happened, his reply was, "Please your honour, *only* a *civilian* did it; but he got the worse of it in the end." That a man who had not been in the ranks above a few days should talk with contempt about "civilians", was really amusing.

At the onset, I, unfortunately for myself, passed a fellow with a wretched figure and high prominent shoulders. When stripped, he did not look so bad; but, when in uniform, he certainly was a wretched unsoldier-like object, though remarkably

powerful, as he had been accustomed to carry heavy weights as a bricklayer's labourer. When the regiment assembled, and the poor fellow got his uniform, he was sent to me by the captain of his company with a note, asking what was to be done with him, as his coatee would not meet; "that he spoilt the company, and could not do the drill." I saw at once the oversight I had made in passing him at all, but I had no resource but to make the best of it now, as young officers were constantly wanting their stupid awkward looking fellows to be discharged as unfit for the service, and I would not consent to certify; so I wrote back in reply, "that the man must be supplied with a larger coatee, must practise extension movements, be well drilled, and made to stand erect; and that I could not answer for all the recruits being made alike, or having equally good figures." One of our officers, a very clever caricaturist, sketched my friend, and christened him "the doctor's dromedary", and affixed my official note at the bottom of the sketch, which was exhibited at our first public mess, presided over by the late estimable and high minded Lord Beaumont; and the caricature was handed round, much to the amusement of all the party. I was not so foolish or thin skinned as to feel annoyed, but quite the contrary. In fact, in the public service, you must be able to stand up for yourself, and defend your own opinion, right or wrong, if you are to have any comfort at all in the discharge of your duty.

A colonel of a flash Hussar regiment of which I had medical charge, once sent a recruit back to me that I had passed, with the remark, that the man was not good looking, and had an indented nose, and was not fit. I replied, that it was impossible for all his men to have Roman or Grecian noses; and that, as his officers and men were *all* such handsome fellows, they could well afford to admit a man to form a contrast. This seemed to please him, and he accepted the recruit. To have a regiment, as the Emperor of Russia has, of all *pug-nosed* men, is certainly a master of taste!

After the incident just named, I took an early opportunity of getting rid of my "dromedary", by recommending him to claim his discharge under the old Militia Act, requiring only fifty-six days service, the operation of which act also enabled us to get rid of a few other unpleasant and by no means elegant looking customers; so that, when the General inspected the regiment, he congratulated the Colonel on the fine body of men he commanded, and me on the highly satisfactory state of the hospital. In truth, the regiment did its duty, and furnished more than the average proportion of volunteers to the line, particularly to the Scots Fusilier Guards—so many, that the Colonel, the Duke of Cambridge, wrote to our commanding officer to acknowledge the services of the regiment. Afterwards, one of our young officers got a commission presented to him in the Duke's regiment, and four of our other officers obtained commissions without purchase in line regiments.

I must now bring these observations to an end. I have only to add that, after some hesitation, the Government admitted the claims of the militia surgeons to compensation for their services and the sacrifices made by them, and awarded a gratuity of twelve months pay, as *some* acknowledgment due to them. When we bear in mind that, out of 70,000 embodied militia, 38,000* volunteers replenished the line in less than three years, when our army was almost annihilated in the Crimea, by disease and deprivation as much as by the fortune of war, and in its utmost extremity for want of men, it must be admitted that the militia branch of the service nobly fulfilled its mission, and formed then, as it ever has done in its history of former times (as testified by Wellington and others), and will form again, an efficient and patriotic army of *reserve*, of which Great Britain may feel justly proud.

At the commencement of these observations, I stated that, out of 2,000 recruits first inspected for the militia nearly three years ago, above one-half of them could neither read nor write. Recruits for the line I found to present a still greater amount of ignorance. In this statement, I give those men credit for being able to read, though, according to their own admission, they can do so only "a little", or "a very little". I have just looked over my recruit register for the last six weeks, and find that, out of the 300 recruits last inspected, 105 can neither read nor write. This shows a greater proportion of ignorant men than was presented in the militia three years ago. Surely this evidence of the deplorable want of education amongst the labouring population shows the necessity of adult schools, both military and civil. Men in the public service have time to attend school and receive instruction, and, in my opinion should be compelled to do so, either during the day when their duty is over, or in an evening. Regimental libraries (or village lending libraries), recently established with the best intentions, are of little use without readers. It is painful, and discreditable to those in authority, to reflect on the amount of ignorance existing amongst such a fine body of men as are now serving their Queen and country. Means ought to be taken to improve their minds as well as their bodies. By intellectual cultivation, crime would diminish, the good conduct list would be rapidly augmented, and promotion more readily ensured.*

[Errata. In Mr. Ikin's last paper, page 2, col. 1, top line, read "*these*", instead of "*this*". Also, at page 2, col. 2, read "a guard-book for keeping in regular *series*," instead of "*lines*".]

CASES OF LITHOTRITY.

By William Thomas Bell, Esq., Great Grimsby, late House Surgeon to the London Hospital.

Summary. *Failure of Operation from Impaction of a Fragment of Calculus: Lithotomy one year afterwards: Recovery.*

William Willson, aged thirty-two, agricultural labourer, of light complexion, sandy hair, good stature, and well formed, although worn down by his sufferings, came under my care in October 1853, with well marked symptoms of calculus in the bladder. I sounded him, and readily detected a stone of considerable size. His bladder symptoms were severe; for which I ordered him to keep his bed, and prescribed the following medicine.

℞ Sodæ bicarbonatis gr. lx; tincturæ hyoscyami ♏lxxx; spiritûs ætheris nitrici ʒiss; tincturæ opii ♏xxiv; aquæ cinnamomi ʒviiss. M. Fiat mistura cujus capiat cochlearia ii magna 4tis horis.

I also ordered a hip bath at night, and a ten grain suppository of compound soap pill, and the bowels to be regulated with castor oil. He soon improved under this treatment; so much so as to fancy the stone did not exist. In about ten days I performed lithotrity, and had some difficulty in retaining my hold of the stone from its polished surface and hardness; at last it was freely broken up. After three operations at moderate intervals, a fragment became impacted in the prostate gland; evidently a broad flat piece, because a good sized catheter could be passed over it into the bladder without much difficulty; for its removal I tried every possible means that could be thought of either to extract it, break it, or push it back into the bladder. This proved tedious, and the poor man's funds became exhausted. He went home, a distance of twenty miles, to try to raise funds to complete his cure. He commenced work, which he followed as long as he could. There was a stricture just below the glans penis, dilated with bougies; this proved an obstacle to the passage of fragments, requiring interference to remove them. A good deal of stone was passed after the third operation.

A year afterwards, in Jan. 1855, he again returned to me with his former symptoms. Upon sounding him, I distinctly felt the fragments of stone in the prostate. After he had had a few days rest and aperients, I performed the lateral operation of lithotomy while he was under the influence of chloroform, and removed a large quantity of broken calculus, including some large pieces, with the forceps and scoop, and by frequently syringing out the bladder with tepid water. The portion from the prostate came out during the operation. The day after the operation he had a little shivering and sore throat; most probably from cold caught during the operation. Independently of this, he had not one bad symptom; he made a good recovery in a month. I have seen the patient quite recently, two years after the operation; he remains in perfectly good health.

* In a previous note, I stated that 33,000 volunteers replenished the line; it should have been 38,000.

* The number of crimes recently so common has been attributed to disbanded militiamen, as well as to ticket of leave men. I am glad to contradict this as far as the 4th West York Regiment is concerned; for, on inquiry made at the Borough Gaol, I find that only five prisoners from the 4th West York have been sent since May 1st, 1856, and these for desertion before disembodiment, or for unlawfully enrolling in other regiments. Not one prisoner for felony has been received.

Lectures

ON CERTAIN VIEWS ON THE NATURE AND TREATMENT OF PHTHISIS BY PHYSICIANS.

DELIVERED AT THE

BROMPTON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST, IN THE SUMMER OF 1856.

By EDWARD SMITH, M.D., LL.B., B.A., Licentiate of the Royal College of Physicians; Assistant-Physician to the Hospital, etc.

LECTURE I (*concluded*).

RESEARCHES AS TO THE QUANTITY OF THE INGESTA AND EGESTA, SHEWING THAT PHTHISIS IS NOT ESSENTIALLY DUE TO DEFICIENCY OF FOOD, DEFECT IN DIGESTION, OR WASTE OF FOOD.

WE will now proceed to consider, with some detail, the state of the general system which is co-ordinate with the attack of phthisis, at least at or about the period of origin, and during a large part of the progress of the disease. This may be most conveniently effected by discussing the subjects which relate to the two classes of ingesta, viz., the food and the air; for upon these two processes mainly the health of the system must be dependent. The former will occupy the remaining part of this lecture, and the latter the next lecture.

Food. The appetite does not in general differ materially from that of health; it is said to be somewhat increased, but I have not found in the majority of patients any state which would warrant me in affirming that there is any decisive change induced by the disease. This will of course imply both that the enjoyment of food continues, and also that the quantity of the food taken is, in ordinary language, sufficient. I cannot adduce any other facts to corroborate this inference respecting the degree of enjoyment (and none are needed); but I can prove that the quantity of food actually taken by phthisical patients is equal to the healthy standard. (See *British and Foreign Medico-Chirurgical Review* for April 1856, with diagrams in the number for July 1856.) During the past year, I prosecuted an inquiry into this subject on fifteen male in-patients of the hospital, and weighed with great accuracy, I believe, all the fluid and solid food which they took during a whole month. The patients were of different ages, and in various stages of the disease; and a few of them were not only in the advanced stage, but had the general system much emaciated and enfeebled. The returns thus obtained are very voluminous, but a simple statement of the average results will suffice.

The subjoined table shows the average daily quantity (in ounces avoirdupois) of solid food, and of meat and bread; also the average daily quantity of fluid, and of ale and porter, used by fourteen patients for a month during May and June; also the average daily weight (in ounces) of undesiccated fæces passed by them during the same period. The cases are arranged in the order of quantity of solids in the urine, beginning with the highest.

No. of case.	Solid food.	Meat and fish.	Bread.	Total fluids.	Ale and porter.	Fæces.
69	40·1	6·8	21·7	103·0	15·1	7·0
95	32·3	6·2	18·4	72·2	8·2	7·5
107	21·1	5·2	9·1	83·3	14·7	7·8
88	22·3	5·4	8·7	53·0	19·0	2.41
79	30·1	4·1	14·0	63·3	8·7	9·6
75	21·6	4·3	9·1	60·0	8·0	5·65
46	26·6	3·8	15·6	67·0	10·0	5·21
80	28·8	4·7	14·0	62·6	7·4	4·75
51	14·7	5·0	6·8	92·8	8·0	5·85
90	21·7	4·2	8·6	43·6	2·4	6·14
58	31·4	5·2	16·6	82·6	8·0	7·55
73	15·2	3·1	8·4	62·0	9·1	2·6
85	19·7	3·7	7·1	54·8	8·0	4·82
77	19.0	4·0	8·2	51·3	10·0	2·34

It thus appears that, on the total average of fourteen patients taken for the period of a month in May and June, the quantity of solid food per day was 24¾ ounces, and that of this quantity were 4½ ounces of cooked meat without bone, and ¾ pound of bread. These average quantities differed much in the several cases, as the quantity of food in health differs, according to the stature and other peculiarities of each person, and were the least in the most advanced cases of phthisis. The highest average occurred in a soldier, 6 feet 1½ inches high and 13½ stones in weight, and was to the extent of 40 ounces per day, and of that nearly 7 ounces were cooked meat, and nearly 22 ounces were bread. The lowest average was in an advanced and shattered case, of short stature and light weight, and was 19 ounces per day, of which were 4 ounces of cooked meat, and 8½ ounces of bread. The average of the seven less advanced cases was 27¾ ounces of solid food per day, including 5·1 ounces of cooked meat, and 15½ ounces of bread; whilst, in the seven more advanced cases, the average quantity was 21½ ounces of solids, including 3·6 ounces of meat and 10 ounces of bread.

In estimating the value of these figures, we must not forget that, even in the least advanced case, the duration of the disease had been for a long period, and the amount of deposit or destruction, or both, considerable; and also that all the cases had become emaciated to a greater or a less extent. In referring to the results of these experiments, I therefore take the strongest argument against myself; for, as my aim is to prove whatever may be causative of phthisis, I at least go far enough when I take cases of the earliest deposition, and too far when the disease, by long continuance, has reacted upon the system. If, therefore, in the latter case, it can be shown that the quantity of food taken into the system is equal to that in health, *à fortiori*, the argument would be strengthened if we could refer to conditions existing at an earlier period of the disease.

Now, if we refer to our own experience, or to the dietaries of public institutions, we cannot doubt that the quantities of solid food thus given, on the averages, in early phthisis, are equivalent to that which is taken in health. But, since the appetite, whether in health or disease, varies much in the long period of a month, and since in phthisis it is hardly possible that a whole month should pass without some complication having appeared which would doubtless modify the appetite, we may gain a truer representation of the amount of food taken by considering the daily returns of the cases. This I cannot do in detail; but I shall refer to the case of the Life Guardsman, No. 69, who took the largest amount of food. From May 15 to 31, the largest quantity on any one day was 49 ounces, and the smallest 40½ ounces; and, on the average, the quantity was 45 ounces, or nearly 3 pounds in weight, against 40 ounces on the average of the month. After May 31st, his appetite failed from an inflammatory complication; so that, on one day, he took no food whatever, and on the remaining days until June 11th, the quantity varied from 20 ounces to 38½ ounces. In this case, the quantity of meat per day, from May 15th to 31st, varied from 6 to 11 ounces, and subsequently from nothing to 9 ounces; whilst that of bread varied in the former period from 22 to 30½ ounces; and in the latter period, from nothing to 20 ounces.

This case forms one end of the table; but if we take one at the other end, which was under observation for a month, and was in a most shattered condition, we shall find great variation from day to day. Thus, in case No. 85, the quantity of solid food varied per day from 13 ounces to 23½ ounces, and of meat from 2½ ounces to 6 ounces, and of bread from 5 to 10 ounces.

A careful perusal of the tables in each case cannot fail to teach that, in uncomplicated phthisis, in the earlier stage, the quantity of solid food is equal to that taken in health.

Now, if we turn from such facts as those now given to the impression which is left upon our mind by careful inquiry from numbers of patients who come under our observation, the same result is obtained. It is my practice amongst the out-patients to note the state of the appetite; and I affirm, with every conviction of truth, that in but a small minority of the cases is the appetite not good, or the quantity of food taken or desired less than their ordinary standard. That, in some instances, the appetite should be insufficient or unsteady, either for a longer or a shorter period, would not be by any means peculiar to disease, much less to phthisis, and has no weight in opposition to the general results.

The quantity of fluid food which was taken in the long inquiry before referred to is not so important to our subject, since that might depend upon other conditions than a desire for nutrition. It consisted, however, in part, of nutritive materials, such as milk, beer, wine, and beef-tea; but the larger quantity was of tea, coffee, and water. It may, however, render the argument less incomplete, if we refer to it; and it may also be of interest, if considered without much detail. (See Table.)

On the total average, the quantity of fluid per day in each case was 70 ounces, or 3½ imperial pints, which quantity in-

cluded half an ounce of wine and 10 ounces of ale and porter. It was the least in the most advanced, and the greatest in the least advanced cases; and when the fourteen cases are divided into these two classes of equal numbers, the quantity is 64 ounces and 72 ounces. The case which took the largest quantity of solid food took also the largest quantity of liquids; and in that the latter was, on the average, 103 ounces, or more than 5 imperial pints. The least average was found in one of the advanced cases, No. 90, and was 43½ ounces. There was much variation in this quantity from day to day. In the cases which took the largest quantity, it varied from 66 ounces to 127 ounces; and in that which took the least, the variation was from 34½ ounces to 54 ounces.

Thus, on the average, the proportion which the fluids bore to the solids in the food was somewhat less than as 3 to 1, and it varied in the different cases from as 2 to 1 to as 4 to 1. The total quantity of ingesta on the whole average was 93 ounces, or nearly 6 avoirdupois pounds weight per day. In case No. 69, it was as high as 143 ounces, or 9 pounds in weight; and in the case which took the least food, it was 70½ ounces, or one-half of that taken by case 69. The total average in the seven cases the least advanced was 99½ ounces, and in the remaining seven cases it was 85¾ ounces. Case 69 took 170½ and 172½ ounces of ingesta in two succeeding days, or a total of 21½ pounds by weight; whilst the largest quantity taken in one day by the most advanced case was 90 ounces, only one-quarter of which was solid.

It is not my present purpose to show the effect which phthisis has in its ultimate progress in lessening the quantity of the ingesta; but it is evident from the above mentioned facts, that the quantity of both solid and fluid food is less in advanced than in early cases. It is, however, clear that, in every stage of the disease, upon the average, there is no inconsiderable quantity of ingesta, especially of a nitrogenous kind; and that the diminution in quantity is less than the wasting and exhaustion of system would lead us to expect. In the early stages, and for a long period after the first deposition of tubercle, there is no lessening of the quantity or the enjoyment of food; and, as we cannot prove the state of the appetite at the moment of first deposition, since that moment is never known, we are left to the inference, that, as in health, viz., before the first deposit of tubercle, the appetite was good; and, as it was so long after the deposit, it must have been the same at the moment of the deposition. I would, therefore, affirm the rule, that phthisis is not necessarily dependent upon loss of appetite, nor upon an insufficient quantity of food, where it can be obtained.

Having, then, established this fact, the next step will be to consider if the food thus abundantly introduced into the system is duly digested and prepared for the sustentation of the body. Now, the fact of the appetite being continuously good, and the quantity of food being normal, would, *à priori*, show that the food must be duly disposed of according to the usual course observed by the system. Our own experience, as that of our patients, leads to the belief that, wherever the organs concerned in digestion become deranged in their action, we suffer a diminution or loss of appetite, and consequently greatly diminish the quantity of solid ingesta. Then, again, when, from overfeeding or lessened wear and tear of the system, the body experiences repletion, the appetite and quantity of food commonly lessen. Both of these results are quite in keeping with what has long been proved to be a law of nature in the system, viz., that, whenever she cannot use or has no need, she ceases to desire. It is quite true that, in one or two diseases, this law may appear to be set at nought; but, upon the whole, the rule would be universally acknowledged. Hence, on this ground, we should be prepared to believe that the food taken into the system in phthisis is duly digested. If it were not so, it would depend either upon an altered action, and therefore an altered state of the organs of digestion, or upon its being hurried too rapidly through the alimentary canal.

If it depended upon derangement of the digestive organs, it would certainly evince itself by the well known signs of indigestion. We have already inferred that no such state of things exists, by the fact of the continuance of the appetite and supply of food, and we get abundant confirmation of this in our medical practice. I am of opinion that in no stage of the disease is dyspepsia more commonly observed in phthisis than in any other chronic disease of vital organs; but on the contrary, that it is much less marked than in long continued disease of the liver. Much less is it a necessary concomitant of the early stage of phthisis. As a rule, which may certainly be proved to exist amongst the out-patients, the tongue is clean and is remarkable only from a deficiency of blood in its structure, and there is neither tenderness at the epigastrium on pressure, nor pain or inconvenience after meals. Of course, as dyspepsia is the most frequent disease affecting humanity, and the most frequent in hospital practice, it is not unfrequent amongst phthisical patients, who constitute so large a proportion of all cases of disease; but in them as in others, it is only temporary, and is as amenable to treatment as it is in persons otherwise healthy. Pressure over one or both lobes of the liver will not unfrequently give a little pain, and indicate the existence of a condition which otherwise would be most readily referred to the lungs themselves, but which a little blue pill and the ordinary treatment for inactive or congested liver speedily removes. Then, again, I would affirm that in the early stages of phthisis, dyspepsia is not by any means a constant concomitant, and consequently that the latter is not even a necessary effect of, much less can it be a common cause of the former. But all this rather refers to the effect than to the cause; yet if dyspepsia were a common cause, it would surely commonly attend the early stages of the disease. But regarding it at an anterior period and as a cause, I do not think that there is any evidence to show that phthisical persons were especially subject to dyspepsia before the period of earliest deposit, or that dyspeptic persons are peculiarly prone to phthisis. Hence, whilst dyspepsia may occur to phthisical patients either before or after the deposit, it is only to the extent in which it attacks persons otherwise healthy, and is not necessarily or commonly causative of phthisis; and so far it is fair to infer that in phthisical cases, as in health, the abundant food is properly digested.

The other alternative of want of due digestion, viz., the *hurrying* of the food again from the system, can be due only to the acts of vomiting and purging. Vomiting is not by any means common in the early stage of phthisis, nor indeed in any stage of the disease; and we know that it is not frequent in health, or in that condition which immediately precedes the earliest deposition of tubercle. In the later stage of the disease it is sometimes found, and may then in part account for the wasting; but it is then rather the effect of a general irritability attending upon an exhausted system, and of a distended stomach impeding the very limited action of the lungs. In the investigation of 15 patients for a month, only two during that period had vomiting. In one it was considerable, and produced on the average of the month 1·82 ounces per day. This case exhibited great nervous excitability in his temperament, and in the large quantity of colourless urine of very low specific gravity, and he subsequently died of brain disease. He had been intemperate. The other had vomiting to the extent of an average of one-fifth of an ounce per day, and at the same time had diarrhœa and albuminuria. The former was an advanced, the latter an earlier stage of the disease. In the former there were at the same time only 21 ounces of solid food taken per day, although the system had not greatly suffered; a circumstance probably attending upon or due to the vomiting. So also purging is not common in health, neither is it frequent nor peculiar to the early stage of phthisis. I do not know that in the early stage of phthisis there is much change in the frequency of the alvine evacuations; but if there be, it is rather on the side of a deficiency of action. Hence by neither mode is the food once taken into the system unfairly hurried out of it.

But there is yet a third source of evidence in reference to this perfect or imperfect digestion of the food to which reference should be made, viz., the amount of nutritive matter still left in the fæces when they have passed through the alimentary tract. It would not be difficult to determine this fact with accuracy, but my present inquiries have stopped short at this point. In the inquiry to which reference has been made, the quantity of most of the egesta as well as the ingesta was determined; and, so far as that may be a guide, it has been ascertained with a fair amount of accuracy. (See Table.)

On the total average of all the cases on each day for a month, the weight of the fæces was 6·3 ounces avoirdupois, and varied from 2·34 ounces to 9·6 ounces per day; whilst in health, on Lehmann's authority, the fæces weigh from 5 ounces to 7½ ounces. In the seven most advanced cases it was 4·9 ounces, and in the seven least advanced cases 6·4, or a difference of 1½ ounce per day on that average. Thus, in reference to the stage of the disease, it agrees with the ingesta, but the proportion of the fæces to the whole ingesta is even less in the advanced than in the early stage, viz., 1 in 17½ in the former, and 1 in 15½ in the latter; and the proportion of the fæces to the solids only in the ingesta is precisely the same in both classes, viz. 1 in 4·3. So far, then, as quantity is evidence of nutritive quality in the fæces, it is clear that there is no greater waste in the advanced than in the early stage of the disease.

As the fæces in these experiments were not desiccated before they were weighed, they may have been more or less solid, and would thus vary in weight with the occurrence of diarrhœa or with the frequency of the stools. Hence there would not necessarily be a constant correspondence between the weight of the fæces and of the whole ingesta, or of the solid or fluid parts of the ingesta taken separately. The case (No. 69) which took the largest quantity of both solid and fluid food did not have the greatest weight of fæces, but the greatest weight of fæces was found in a case in the early stage (No. 79), in which there were the complications of diarrhœa and excessive albuminuria.

The case which appeared to closely resemble a state of health was a ruddy looking farmer (No. 95), who had one lung sound. On the total average, the weight of his fæces per day was 7¼ ounces, whilst that of the total ingesta was 105¼; so that the former was one-fourteenth of the latter, and as 1 to 4·2 of the solids in the ingesta. This is somewhat more than the proportion which the total average of the cases gives, and consequently shows that as we approach to a state of health the quantity of fæces increases and not diminishes.

It has been stated that when the stools were numerous, the total weight of the fæces was increased. This was seen in case 79, in whom it amounted to 20 ounces on one day, and 16¾ on another day. In case 69 also to 19 ounces in one day, and in case 95 (the healthy looking man) to 19, 19, and 21¼ ounces on succeeding days. The same fact, however, occurs in some instances where there is deficient action, or when an evacuation occurs only once in two or three days. The largest amount passed in any of the cases was in one of very sluggish temperament, who, after passing three days without an evacuation, had one to the extent of 32 ounces, and again another of 20 ounces at a further interval of two days. In this case there was a considerable quantity of food taken, viz., 31½ ounce average. There was, however, an instance of very costive habit, in which, after an interval of two or three days, the evacuation varied only from 5¼ to 8¾ ounces, and produced on an average of a month only 2·41 ounces per day. In this instance, the average quantity of solid food was 22¼ ounces. Thus it is evident that it would be fruitless to expect the fæces to bear the same proportion to the ingesta from day to day, and there is only a very general proportion between them in the long interval of a month.

From the foregoing statements, we learn that, in the cases nearest to health, the quantity of fæces was above the average of the whole cases combined, and was greater in proportion to the total ingesta than in the more advanced cases; and also that, as the disease advanced, the proportion of the fæces became less. Moreover, as, on the total average, the weight of the fæces in phthisis is much greater than in health, there are some grounds for the inference, that the food does not in that disease pass off in the fæces, undigested and unappropriated by the system, at least not to a greater extent than probably occurs in health—a probability infinitely greater when we limit the attention to the condition precedent of the deposition of tubercle. Hence we have not as yet any evidence by which to ascribe the origin of phthisis to the absence of abundant nutriment in the body.

Now, if, in addition to the previously mentioned facts, we add the not insignificant one, that phthisis occurs in all classes of the community, and therefore, in a very large proportion of instances, in persons who must, throughout their whole period of existence, have had abundant and proper nourishment, we must acquit the whole of the organs of digestion, as well as the quality and quantity of food, of any necessary share in the production of phthisis, and, for all purposes of practice, may exclude this subject from our attention.

[The researches into the quantity and chemical constituents of the urine were not completed when the above lecture was delivered; hence they are not inserted in this place.]

ALLEGED CURE FOR SEA SICKNESS. Dr. Landerer, at Athens, announces that he has discovered a sovereign specific against sea sickness. His remedy is to give from ten to twelve drops of chloroform in water. The chloroform in most cases removes nausea, and persons who have taken the remedy soon become able to stand up, and get accustomed to the movements of the vessel. Should the sickness return, a fresh dose is to be taken. It was tried on twenty passengers on a very rough voyage from Zea to Athens, and all, with the exception of two, were cured by one dose. The minority, two ladies, were able to resist the feeling of illness on taking a second dose. *(Galignani's Messenger.)*

Reviews and Notices.

A FEW REMARKS ON THE PERFORATING ULCER OF THE STOMACH AND BOWELS. By J. BOWER HARRISON, M.D., F.R.C.S., etc. pp. 68. London: Churchill. 1856.

IN this little *brochure*, Dr. BOWER HARRISON presents us with some very sensible observations, written in the same easy conversational strain which characterises all his other medical productions. After narrating several very interesting cases, he discusses in succession the diagnosis, treatment, and morbid anatomy of the fatal lesion under consideration; scattering here and there, as he proceeds, a short but highly useful practical remark. For example, he very truly observes that—

"Many cases are recorded with great minuteness which still omit points of the utmost importance in diagnosis. In order to report a case well, we must have some previous knowledge of what is chiefly worthy of observation." (pp. 9, 10.)

The first of Dr. Harrison's cases is an interesting illustration of the practical acumen of the late Mr. Robert Thorpe, of whom Sir James Bardsley so justly observed at the Manchester anniversary meeting, that his knowledge far exceeded his power of expression. The case was that of a female presenting the ordinary symptoms of strangulated hernia, with "a small tumour in the bend of the right thigh, as nearly as possible in the situation of the crural ring." The woman was conveyed to the Manchester Infirmary, where every one thought the case to be one of hernia, with the exception of Mr. Thorpe. After death, the tumour was found to be merely a softened gland; and there was peritonitis from perforating ulcers of the small intestine.

In another case of fatal perforation occurring in a gentleman who, "though only thirty-seven years of age, had a much older look, and might easily have been taken for fifty", the immediate occasion of the fatal rupture of the stomach by perforating ulcer, was an overloaded condition of the organ. The patient "was a man of very abstemious habits, and accustomed to long fasts; but on the morning of the attack he had made a hearty breakfast, and partaken of mutton chops." The author also remarks that—

"Many cases are recorded in which a hearty meal has been the precursor of death by perforation; and others are mentioned in which an emetic has been the occasion of a fatal rupture." (pp. 42, 3.)

As signs of perforation having taken place, it is stated that—

"The pain which ensues rarely or never abates, but becomes more and more severe, until death occurs. Exceptions have indeed been mentioned, but they are certainly rare. The pulse is not always affected at the commencement, and sometimes it remains steady for many hours, and fails only with the approaching collapse. The intellectual faculties are unfortunately too clear, and remain unimpaired to the end. I do not think that there is any peculiarity in the tongue, nor should we expect any. The abdomen mostly becomes tympanitic after perforation has taken place, though, before that occurrence, it is often hard and contracted. If the patient vomit, he does not vomit much; it is an abortive effort, attended with aggravation of pain and flatulence. If fluids be taken—at any rate, when the perforation is in the stomach—there is a dreadful accession of suffering after a brief interval.

"The pain which attends perforation is sudden and violent. It is violent at once, and does not become so by degrees. This in itself is striking, and unlike the more gradual invasion of ordinary inflammation. Again, it is more than commonly violent. The patient says he cannot bear it. He speaks authoritatively, and says he must have relief, or he shall die." (pp. 22-4.)

Speaking of the liability of anæmic young women to this disease, the author observes:

"It would appear that the changes in the molecular constitution of the stomach are more rapid than those of other parts of the body, and that it is the first to suffer when aliment is

withheld. Hence, ulceration of the stomach has been known to attend states of starvation." (pp. 34.)

In regard to treatment, the account is not a hopeful one. In the preliminary dyspepsia which may be supposed to indicate the existence of gastric ulcers prone to produce perforation, the main consideration is attention to the feeding of the patient. His food must be given in small quantities at once, and must be unirritating in quality. "A due regulation of the food is paramount to all other considerations." Opium, bismuth, iron, and aloes, are spoken of judiciously and approvingly. Of nitrate and oxide of silver, Dr. Harrison has not had much experience. When perforation has occurred, "opiates and rest are our chief reliance; and the hope of recovery is small indeed."

We commend this little work as containing an excellent and very intelligible sketch of what is known respecting the disease of which it treats.

On Artificial Digestion as a Remedy in Dyspepsia, Apepsia, and their Results. By Edward Ballard, M.D., Licentiate of the Royal College of Physicians, etc. pp. 46. London: Walton and Maberly. 1857.

The introduction into the list of therapeutic means of pepsine, the digestive principle of the gastric juice, is, Dr. Ballard informs us, due to Dr. L. Corvisart of Paris: and it has received an extended trial and been recognised as a valuable addition to our means of cure both in France and Germany. The following extract from Dr. Ballard's little work will shew how pepsine is to be prepared and employed.

"*Preparation.* The following are the directions given by M. Boudault for the preparation of this medicine. 'Take a sufficient number of rennet bags (the fourth stomach of the ruminants), open and reverse them, and wash them under a thin stream of cold water; scrape off the mucous membrane, reduce it to a pulp, and macerate it in distilled water for twelve hours; filter and add to the liquor a sufficient quantity of acetate of lead, collect the precipitate, and pass through it a current of sulphuretted hydrogen; filter again, and evaporate at a low temperature, and powder the dry residue.' Pepsine thus obtained varies in transforming power, and it was necessary to obtain a medicine whose energy for equal weights should be uniform. With this view it was necessary to assume a standard dose, and this was the quantity of pepsine, which when acidulated with three drops of lactic acid, and added to fifteen grammes of water, would transform six grammes of fresh fibrin, finely cut up, and kept in a bottle at a temperature of 40° centig. for twelve hours, with occasional shaking. This quantity being ascertained, starch is added to bring this dose to the weight of one gramme. The solution of pepsine is now, as we conclude from a recent brochure of M. Boudault, not evaporated to dryness but only to the consistence of a syrup, which is mixed intimately with starch pulverised and dried at a temperature of 100° centig. In this state the whole can be reduced to powder, and a medicine of an uniform efficacy is obtained.

"There are four kinds of 'Poudres Nutrimentives', numbered 1, 2, 3, and 4. Nos. 1, 2, and 3, are acidulated with lactic acid, in the proportion of three drops to each dose of a gramme. No. 4 is neutral, or nearly so. No. 1 is the basis of Nos. 2 and 3, which, as we shall see, contain other active ingredients.

"*Characters.* Pepsine thus procured, and diluted with dry starch, is a rather coarse powder of a light brown colour, not uniform, but evidently consisting of two kinds of powder, which are evenly mixed. It has a slight odour of gastric juice, and a slightly acid, saline taste. It slowly attracts moisture from the atmosphere, when exposed; but, in well-corked bottles, may be preserved for an indefinite time without losing its physiological properties. When water is added to it, the pepsine readily dissolves, the starch with which it was mixed remaining insoluble. The filtered solution possesses all the transforming power ascribed to it. It need scarcely be said that the pepsine contained in the 'Poudre Nutrimentive' is not chemically pure. The process of rendering it so has been followed by the destruction of its physiological properties.

"*Dose and Mode of Administration.* The average dose of the 'Poudre Nutrimentive' is about fifteen grains. This dose rarely need be exceeded. In some instances a smaller quantity may suffice, as where it is administered to infants. It may be taken dry or in solution. In the former case, the dose may be taken in a morsel of unfermented bread; in the latter it may be dissolved in the first spoonful of soup taken at dinner, provided this is cool; or it may be disguised by administration in sweetened water, etc. The principal point to attend to is, that it must be taken with, or at the commencement of the meal on which it is to act. M. Corvisart recommends the following as a formula which meets with general approbation:—

"Take of pepsine 6 grammes (93 grains); dissolve for twelve hours in syrup of acid cherries, 60 grammes (15½ drachms); add elixir of Garus, 15 grammes (3¾ drachms); filter.

"A more ready mode of preparing this syrup consists in first dissolving the pepsine in a little cold water, filtering, and then adding the other ingredients. The elixir of garus may be substituted by an equivalent quantity of syrup of cherries. A sixth part of the quantity is a dose. This mixture of pepsine with syrup must only be made extemporaneously; for, if preserved for a few days, the pepsine acts upon the cane sugar like a ferment, transforming it first into glucose, and subsequently into lactic acid. An advantage to the digestion may, as it appears to me, occasionally be gained by the simultaneous use, with the pepsine, of an additional quantity of lactic acid. No considerable quantity of liquid should precede, or immediately succeed a meal in which pepsine is used; and the same must be said of the drinking of the stronger alcoholic beverages.

"There is another mode in which pepsine may be used to promote the nutrition of the sick. I refer to the previous conversion, by its aid, of the food to be administered into true nutriment. There are cases of disease in which thus, alone, can sufficient support for the preservation of life be possibly introduced; cases where the use of solid animal food is urgently indicated, but in which the patient, from the dryness of his mouth, or other causes, is incapable of taking it; where nothing but liquid or dissolved nourishment can be introduced. These are cases in which medical men seek to maintain life by beef-tea, soups, juice of meat, and nutricious enemata. Now we begin a new era in the nourishment of such patients; we may now furnish them with all they require to maintain life, already digested, and in the form of liquid such as they can swallow, or such as, with improved prospects of success, we may inject into the rectum.

"*Therapeutical Effects.* It may be premised, that, in availing ourselves of the use of this medicine, the food with which it is given must be animal or nitrogenised food. It, nevertheless, does seem to operate, in some degree, upon the amylaceous ingredients of the food; upon such of them, at least, as have been previously transformed into glucose, causing the ultimate conversion of the latter into lactic acid. It is, probably, on this power that the efficacy of rennet in the treatment of diabetes depends.

"An immediate effect of the administration of a dose of pepsine in dyspepsia, is sometimes, but not invariably, noticed in the production of *appetite* which had previously been absent. A few doses, in most cases, are followed by an appetite for subsequent meals; and where but little food could be taken without disgust at the commencement of the treatment, it often happens that full meals are shortly taken with pleasure. In those instances where voracious appetite accompanies prolonged diarrhœa, from the apepsia of infancy, the appetite becomes reduced, as soon as the effect of the general improved nutrition becomes marked.

"The relief and rapid disappearance of painful sensations after meals, is a more marked effect of the use of pepsine in cases of *dyspepsia*, arising out of defective or imperfect secretion of the gastric juice; and the same thing may be said of the arrest of the vomitings, which are due to the same cause; and of flatulent distensions that arise from the chemical decomposition of the aliment."

For a further account of the benefits to be derived from the use of pepsine, and for a series of illustrative cases, our readers are referred to the book itself. The principle on which this remedy is administered is physiological and simple; and if it prove as efficacious in the practice of others as it has been in that of Dr. Ballard and the continental physicians, a valuable addition will have been made to our therapeutic stores.

DE LA RUE'S MEDICAL MEMORANDUM BOOK AND INDELIBLE DIARY: 1857. Edited by a Physician. London: John Churchill.

THIS is one of the best pocket-books which a medical man could possess. In addition to its well arranged diary, it contains an amount of information on points which specially interest the practitioner, such as he will find in no other diary that we have seen. The days of meeting of scientific societies, the fees allowed by law to medical practitioners, the names of all officials in any way connected with medicine, are all duly recorded; in addition to which, short hints are given with respect to matters in which even the best and ablest medical man may for a moment be at fault, such as the antidotes for the various poisons, the numerous signs of pregnancy, the relative strength of the various wines and spirits, and the proportions of the most active ingredients used in the more important preparations of the London *Pharmacopœia*. This little pocket-book is, in fact, to the general practitioner, only second in importance to his pocket instrument-case.

THE LIVERPOOL MEDICO-CHIRURGICAL JOURNAL. No. I. January 1857. pp. 146. Liverpool: Walmsley. London: Churchill.

THE AUSTRALIAN MEDICAL JOURNAL, edited under the superintendence of the Victoria Medical Society. Nos. I, II, and III, January; April, and July, 1856; each No. 80 pp. Melbourne: T. M. Buzzard.

WE have placed together the names of two new medical periodicals, one of which is issued by the profession in Liverpool, while the other represents the state of medical science in one of our most flourishing colonies on the other side of the world.

The *Liverpool Medico-Chirurgical Journal*, its conductors state, is intended to "incite to literary exertion, both in that town and elsewhere, those whose opportunities and abilities well qualify them for the task, but who have hitherto lacked the initiatory stimulus." We wish our *confrères* success in this object; but they must not be sanguine. The *Journal* is to be a quarterly publication: and if the first number be a fair specimen of the work, it will certainly be very creditable to the profession in Liverpool. We shall have occasion to refer to some of the articles under their proper classes in the Periscope or elsewhere; but, in the mean time, the following list of titles will show what our Liverpool brethren have put together in print as their special contribution to the instruction of the profession:—

"A Sketch of the Medical History of Liverpool. By F. D, Fletcher, M.R.C.S. Six cases of Lead Poisoning. By T. Inman, M.D. Slow Poisoning by Antimony. By J. Birkbeck Nevins, M.D. Artificial Enucleation of a Large Fibroid Tumour of the Uterus, with some Remarks on the Surgical Treatment. By T. F. Grimsdale, Esq. Concealed Accidental Hæmorrhage. By L. E. Desmond, Esq., B.A. Excision of the Shoulder-Joint. By E. R. Bickersteth, F.R.C.S. Seven Cases of Transfusion of Blood. By Alfred Higginson, Esq. The Cachexia of Young Children. By E. Whittle, M.D., M.R.I.A. Cases of Continued Fever. By Robert Gee, M.D. Case of Idiopathic Tetanus. By J. Sinclair, M.D., M.R.C.S. Case of Stone in the Bladder, Lateral Lithotomy, Recovery, with Union by the First Intention. By J. Nottingham, M.D., F.R.C.S. Case of Mollities Ossium of the Clavicle. By James Hakes, Esq. Abstract of the Proceedings of the Medical Society."

The Australian Medical Journal is, we believe, the first publication of the kind which has appeared in the colony whose name it bears. It is conducted by a committee of the Medical Society of Victoria; and the numbers which have reached us are marked by the practical character of the communications, as well as by the sound moral tone maintained in regard to the social and political affairs of the profession. Under such guidance, true scientific medicine will stand its ground well in Australia.

Periscope.

PRACTICE OF MEDICINE AND PATHOLOGY.

TREATMENT OF ASPHYXIA.

Two articles on the important subject of the treatment of Asphyxia have lately appeared in the medical journals, and an abstract of them is subjoined. The opinions of Mr. Jennings of Malmesbury are already well known to the readers of the ASSOCIATION MEDICAL JOURNAL.

RATIONALE OF THE FATAL TENDENCY OF THE WARM BATH IN ASPHYXIA.

In a paper published in the *Lancet*, Dr. MARSHALL HALL says that an animal dies in air consisting of such a proportion of carbonic acid with oxygen as to prevent the evolution of carbonic acid from the blood. If, without producing sudden effects, we change the relative proportion of the respiration and the circulation, morbid phenomena are produced special to each case. If the circulation be disproportionately augmented, carbonic acid is formed and morbidly retained:—slighter convulsion and slower death ensue. If the respiration is unduly and disproportionately augmented, the animal is cooled; for mere pulmonary respiration is a cooling process, by the difference of temperature of this inspired and expired air; and in this case also the animal dies, but now from loss of temperature. This latter is the case in the asphyxiated patient, if the respiratory movements be unduly hastened—that is, disproportionately to the rapidity of the remaining circulation. On the other hand, if in the asphyxiated we excite the circulation without simultaneously and proportionately inducing the respiratory movements, we destroy our patient by carbonic acid, formed in the course of that circulation, and uneliminated by respiration.

The warm bath in asphyxia is injurious, and has, Dr. Hall is convinced, of itself proved fatal in cases in which the patient, without it, would have spontaneously recovered. Warmth is so obviously a stimulus, and a stimulus is so apparently required for a patient taken out of the cold water in a state of asphyxia, that in recommending the warm bath we seem to be addressing ourselves to the common sense of mankind, and it was a step in advance to entertain a doubt on the subject.

But when we begin to experiment—when we learn that an animal deprived of respiration by being submerged under water, lives longer in cool water than in warm water, we learn to consider whether, in fact, coolness is not more favourable to life in the asphyxiated from submersion, than warmth. Animals bear the abstraction of respiration in proportion to their coolness: the hybernant animals and the batrachian tribes will scarcely drown at all. If a kitten be first cooled, or if it be immersed in cool water, it will not drown so soon as it would do if submerged at its ordinary temperature in water of the same temperature. There are other facts which point to other modes of treatment of the drowned, which the administration of the warm bath necessarily excludes. If a poor creature be perishing for want of food, we cautiously administer food. If a man be, in like manner, perishing for want of air, should we not administer air? And in the case of drowning, is not the want of air the first condition to which we should bring succour, and the want of temperature the second or third? Then in drowning we should administer air first and warmth in the second place. Warmth administered without air raises the temperature, and in so doing augments the necessity of respiration to life. If any effect be produced by the warm bath, the circulation is accelerated. But to accelerate the circulation without inducing, at the same time, efficient respiration, is to augment the formation of carbonic acid without its elimination from the system. Secondly, all excited respiration through the medium of the cutaneous excitor nerves is excluded, the uniform temperature of the warm bath excluding the excitants of those nerves arising from the alternate application of heat and cold to the surface; and thirdly, imitated respiration is excluded by the very sustained position of the patient, excluding, as it does, alternate pronation and rotation, and pressure applied and removed, or changes of position and compression, which induce respiratory movements. So that the warm bath is not only positively injurious by poisoning, but negatively, by excluding the de-poisoning process. Lastly, the warm bath excludes those frictions of the limbs upwards, with pressure, which really constitute the most effectual means of promoting the circulation and warmth. Nor is it unimportant to save the time expended in preparing the warm bath, or in carrying the patient to it.

JUGULAR VENESECTION IN ASPHYXIA.

Dr. John Struthers of Edinburgh, in a paper published in the *Edinburgh Medical Journal* for November 1856, advocates the practice of opening the external jugular vein in cases of asphyxia. He refers to the ascertained fact that the right side of the heart may be disgorged in animals by jugular venesection, with the result of increasing the action of the heart when it has become feeble. A point which remained to be ascertained was the amount of obstruction which would be offered to the reflux of blood by the valves in the veins of the neck. Dr. Struthers gives a description of these valves, and details some experiments which he performed on the dead human body with the object of ascertaining whether or not fluid would pass these valves. It appears that the valves do sometimes offer an obstacle, but that this may be overcome by the introduction of a catheter; and that regurgitation does not readily take place from the external jugular vein unless it be so distended as to overcome the action of its terminal valves.

In making the practical application of what has been said, Dr. Struthers observes that, the remaining indication beyond the maintenance of artificial respiration, in the treatment of asphyxia, is specially to restore the action of the heart. The stagnation at the lungs produces accumulation of blood in the right side of the heart, distending and at length paralysing it, the action of the heart continuing a short time after respiration had ceased. It may be asked, Why does restoration not quickly follow well performed artificial respiration, after a short immersion? The natural relation between the lungs and the air has been restored, and respiration is going on. All that would seem to be now wanting is the forcing power of the heart to drive the blood onwards; but the pulmonic heart is paralysed by a mechanical cause, which, unless removed by regurgitation, must or may render fruitless all attempts at resuscitation.

In regard to this important indication, Dr. Struthers infers, from his experiments on the human subject, and from the general view he has presented of this inquiry—1, That it is generally possible to disgorge the right side of the heart by jugular venesection; and 2, That there is every reason to believe that jugular venesection will prove a useful means in resuscitation.

In jugular venesection under other circumstances we make pressure below the opening, and the blood flows from above. This proceeding is to be regarded as a general bloodletting, as in bleeding at the arm, and in addition, as a local bloodletting to the head; as a more direct and rapid means of relieving congestion of the head generally, and pressure on the brain from venous obstruction. In asphyxia, jugular venesection may possibly be useful on this principle also, as well as on the much more important principle of regurgitation; but it is to be borne in mind, as my experiments show, that the blood which comes from above may still be a regurgitating current from the internal jugular, on account of the very free communication which always exists at the upper part of the neck between the various jugular veins of the same side, enabling injections to pass readily from one to the other.

There is one danger attending this procedure—that of entrance of air into the veins. This accident is especially apt to occur at the root of the neck, where the veins do not collapse easily, but are kept open, or "canalised," by their relation to the bones; so that during the act of inspiration, air is very liable to enter. To leave a wound in the external jugular vein in an open condition during the performance of artificial respiration, would therefore place the patient in very dangerous circumstances. It is, however, evident that air cannot enter as long as the veins are distended or full. The danger then may be obviated by closing the wound as soon as the blood ceases to regurgitate actively. Recollecting that our object is not to empty, but only to relieve the over-distension of the auricle and ventricle, the escape, by regurgitation, of even one ounce, should afford very material relief. As, however, part comes from above, the safe plan is not to close the wound until the blood ceases to flow actively.

In the great majority of the drowned, although the body is early recovered from the water, the vital actions have ceased; means of resuscitation are usually continued for perhaps an hour or more; and the means commonly had recourse to, after stripping and drying the body, are warmth and friction, and attempts to restore respiration by artificial means, or by galvanism.

Dr. Struthers would recommend jugular venesection to be performed *as early as possible;* that the vein should be opened at about an inch above the clavicle; that the veins be simply allowed to disgorge themselves; and as soon as the active flow ceases, not waiting too long, that the wound should be carefully closed, and artificial respiration immediately commenced.

With regard to assisting the regurgitation, he would not be disposed to interfere if the blood came with even moderate freedom. If it did not, it might then be advisable to introduce a probe, or blow pipe, or instrument like a female catheter, and slip it gently in the direction already mentioned, for about a couple of inches. If this be not succeeded by a regurgitating current, then abandon the procedure, and close the wound. The patient has had all the chance which the surgeon can give of the benefit which, he believes, jugular venesection will generally confer.

British Medical Journal.

SATURDAY, JANUARY 10TH, 1857.

THE LUNACY ARISING FROM PUERPERAL FEVER: IS THE PATIENT'S DETENTION FOR LIFE JUSTIFIABLE?

The dreadful murder last week of two young children by their mother, Martha Bacon, in Kennington Lane, draws our attention to the commission by women of deeds, deemed horrible crimes by the informed public, but for which in reality they are not properly accountable. The poor woman who put an end to her two children's lives, it is admitted on all hands, is a lunatic. Her unmeaning tale about the men who broke into her house and cut her own and her children's throats—her vacant stare at the witnesses as they gave their evidence—so strongly stamped her case, that every one in court felt the impropriety of placing such a poor creature in the dock of a court of justice. Had a medical man versed in lunacy witnessed this examination, he would at once have jumped at the conclusion that he saw before him a person who had gone insane in consequence of an attack of puerperal fever. And this, we are given to understand, is actually the case. Martha Bacon was attacked with this fearful malady immediately after the birth of her last child, fifteen or sixteen months since, and between that and the present time has been an inmate of the Lincoln County Asylum. Those who have seen much of puerperal fever are aware that in the delirium which attends it, the mother but too often directs her violence against her own children. Over lactation often results, as our associates well know, in insanity, which, in a similar manner, shows itself in the commission of acts of infanticide. Mrs. Brough, who murdered her six children some time since, was an example of this class of lunatics. This woman was the nurse of the Prince of Wales, and was dismissed from that responsible office on account of severe headaches; these headaches terminated in that "terrible black cloud" of the brain, under shadow of which in one night she made a clean sweep of all her little ones. This woman, who very narrowly escaped hanging, is at the present moment an inmate of the criminal wards of Bethlem, and is, at times, of decidedly unsound mind. There are many women, however, in this asylum at the present moment incarcerated for life, by the order of the Home Secretary, for crimes committed during the delirium attendant upon puerperal fever, who have recovered their reason, and it is to the hardship of

their cases that we wish to draw public attention. As long as a criminal lunatic of this class is within the childbearing age, no doubt it would be unsafe to let her loose again upon the world, as relapses but too often occur during subsequent confinements; but we cannot conceive on what grounds perfectly sane women, past the change of life, are confined as state prisoners. The conditions which brought about their former insanity cannot by possibility occur again; and to continue their confinement is to punish them for acts committed years before, at a moment when they were no more accountable for their actions than they would have been for those committed during an attack of brain fever. The injustice done to these poor women is not felt so much, perhaps, at the present moment, as there are but few of them in our public asylums saved from ignominious deaths by the merciful intervention of our own profession, but year by year we shall certainly see an increasing number snatched from the gallows by the juster ideas now obtaining with repect to the responsibility of women who commit meaningless crimes, such as those we have already quoted, and then it will be no longer possible to continue the present unjust system of perpetual confinement.

THE LATE HUGH MILLER.

THE sudden death of Hugh Miller, one of the most laborious of men of science, and classical of English writers, is by this time too well known to require a detailed account of its occurrence. Suffice it to say, that Mr. Miller was found on Wednesday, December 24, shot through the heart with a pistol bullet. The well known character of the man led to the hope at first that the melancholy event was the result of pure accident, he having been in the habit of keeping a loaded pistol in his bedroom, from an apprehension (which was not without grounds) of danger from burglars. An investigation, however, of the circumstances attending his death, made by Professor James Miller and other medical men, together with a knowledge of the influences under which he had been placed, leave no doubt that the act was suicidal. The conclusion drawn by Professor Miller is embraced in the following words:

"The cause of death we found to be a pistol shot through the left side of the chest, and this we are satisfied was inflicted by his own hand. From the diseased appearances found in the brain, taken in connection with the history of the case, we have no doubt that the act was suicidal, under the impulse of insanity."

The subjoined extract from the *Witness* newspaper—of which, in addition to his scientific pursuits, Mr. Miller was the editor—gives an idea of the condition to which his mind had been overworked.

"For some months past his overtasked intellect had given evidence of disorder. He became the prey of false or exaggerated alarms. He fancied—if, indeed, it was a fancy—that occasionally, and for brief intervals, his faculties quite failed him, that his mind broke down. He was engaged at this time with a treatise on the *Testimony of the Rocks*, upon which he was putting out all his strength, working at his topmost pitch of intensity. Hours after midnight the light was seen to glimmer through the window of that room which, within the same eventful week, was to witness the close of the volume and the close of the writer's life. This overworking of the brain began to tell upon his mental health. He had always been somewhat moodily apprehensive of being attacked by footpads, and had carried loaded firearms about his person. Latterly, having occasion sometimes to return to Portobello from Edinburgh at unseasonable hours, he had furnished himself with a revolver. But now, to all his old fears as to attacks upon his person, there was added an exciting and over-mastering impression that his house, and especially that Museum, the fruit of so much care, which was contained in a separate outer building, were exposed to the assault of burglars. He read all the recent stories of house robberies. He believed that one night lately an actual attempt to break in upon his museum had been made. Visions of ticket-of-leave men prowling about his premises haunted him by day and by night. The revolver which lay nightly near him was not enough: a broad-bladed dagger was kept beside it, while behind him, at his bed head, a claymore stood ready at hand. A week or so ago, a new and more aggravated feature of cerebral disorder showed itself in sudden and singular sensations in his head. They came on only after lengthened intervals. They did not last long, but were intensely violent. The terrible idea that his brain was deeply and hopelessly diseased, that his mind was on the verge of ruin, took hold of him, and stood out before his eye in all that appalling magnitude in which such an imagination as his alone could picture it."

He appears to have had the idea that he must have walked in his sleep. This he expresses, in terms of agony, in a letter to his wife, which was found lying beside his corpse. "I *must* have *walked*", he says; "and a fearful dream arises upon me. I cannot bear the horrible thought." The same idea appears in his description of his symptoms, as given by him to Dr. Balfour and Professor Miller, who met in consultation on his case on the day preceding his death.

In conclusion, we must, as a duty, animadvert on a fault of omission. While we have no desire to say anything which would increase the regret of those who have known Mr. Miller both in his social and in his scientific relations,—a regret in which, as members of the scientific world, we partake,—we would ask why, after he had described to his professional advisers the symptoms of cerebral disorder, under which he suffered, he was allowed to sleep *alone?* Who knows but that, if he could have been safely preserved by the care of a watchful attendant through the dread hours of night, the overworked mind might in time have recovered its healthy tone, and an ornament to science have been preserved to us for a longer time?

THE WEEK.

WE trust our associates will not forget that the opening of the year is the time for recruiting our ranks. The resignations, we believe, have not equalled the new admissions; nevertheless we should not feel satisfied with merely keeping our numbers at the same level. It should be remembered that our force would be doubled if every associate were only to find us one recruit from among his friends, and we trust that they will use their influence accordingly. As it is, the Association is the only really powerful body in medicine, and it lies within our own power to make it the directing influence on all matters pertaining to our science.

Dr. Mayo has, contrary to expectation, been elected President of the Royal College of Physicians, in place of the late lamented Dr. Paris. As we explained in our last number, the choice for this important and dignified office is but limited, inasmuch as out of the large number of Fellows of the College of Physicians, the elects (only seven in number) have the power of selection. It cannot be denied that the system which narrows the field in this manner is a bad one; but this, we regret to say, is not the whole of the evil. The election generally takes place on the principle of seniority; and thus a bonus is given to longevity rather than to eminence. It is certainly strange that

a learned profession should consent to be governed by a system which has been repudiated in the army; and which, indeed, is about to be abolished in the medical service of India.

These remarks are made without the slightest wish to disparage Dr. Mayo, whom we believe to be a thoroughly worthy man. He was, at Oriel, a contemporary of Whateley, Arnold, and Newman; and has, for many years, devoted his attention to mental phenomena, on which he has thrown much light. It is needless to state that Dr. Mayo has passed the age of active life. This, however, is the fault of the method of his election, which, we have reason to believe, will before long be entirely reformed.

The Inquest on Mr. William Marcooley, of Brompton, has terminated with a verdict of manslaughter against Joseph Burrows, the assistant of Mr. Budd, the chemist in Brompton Row. It appears that this person carelessly supplied a drachm of Scheele's prussic acid, in place of a dose of castor oil; and the consequence was the immediate death of the unfortunate deceased, when he swallowed what he conceived to be an innocent aperient. It appears that the assistant was attempting to do two things at once; to supply the oil to one customer, whilst he was making up a lotion, containing the deadly quantity of prussic acid, for another. This case seems to prove that no legislative enactment can possibly provide against the carelessness of individuals, as it would appear that every precaution was taken in Mr. Budd's shop against the misplacement of poison bottles, by the method of keeping them in a separate cupboard.

Another case of poisoning, happily not fatal, has occurred during the week. A poor sempstress, miserable and hopeless, attempted to poison herself and child with laudanum. She purchased the drug at four different chemists. The only method of stopping the sale of deadly drugs to the public, would be to publish the name of every individual who supplied them in cases such as this, where the facts come out before the police magistrate, and are published in the daily newspapers. If a dozen druggists were posted in this public manner, we will engage that a stop would be put to the indiscriminate sale of poisons.

We regret to have to announce in our obituary of this day another addition to the long list of those members of our profession who have fallen victims to their zeal in the discharge of their duty—we refer to Mr. Henderson, a student of St. George's Hospital, who died last week of scarlet fever, contracted while performing, for a short time, in the absence of a friend, the duties of House Surgeon to the Hospital for Sick Children. The deceased was a young man of much promise, distinguished for energy and unwearied activity in the search for professional knowledge. He had acquired by industry in one of our Colonies the means of pursuing his studies in England; and had come over here with the laudable ambition of obtaining such knowledge of medicine as would enable him to provide for relatives in Australia, who are now left destitute by his untimely death. The shortness of the time at his disposal rendered him perhaps imprudently diligent in working at the many subjects with which a "general practitioner" ought (especially when remote from professional assistance) to be familiar; and thus the malignant disease by which he was unfortunately attacked found an easy prey in a body exhausted by unceasing labour, and a mind wearied with anxiety and study. It is not, perhaps, a misfortune for any man to die, at whatever period, and however far from those who are dear to him, provided death finds him in the conscientious discharge of his duty; but it is difficult to exaggerate the loss of such a man as we have described to those who are now dating their expectations from the day of his return to them. It may be some consolation to them to know that his worth was appreciated, and his death deplored, by those who knew him here.

It would seem as though there were an epidemic of assassination abroad. The news of the attempt upon the life of the King of Naples has scarcely grown cold, before we hear of the tragical death of the Archbishop of Paris. The dagger of the priest has proved more fatal than the bayonet of the soldier. Just as the archbishop was entering the vestry of the church of St. Etienne at Paris, he was mortally struck by an ecclesiastic named Verger, who drove his weapon with such force into the breast of the prelate, that, notwithstanding the rich embroidery of his stole, it traversed one of the ventricles of the heart, and he died almost instantly, without a struggle.

Reports of Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Tuesday, December 9th, 1856.

Cæsar Hawkins, Esq., F.R.C.S., President, in the Chair.

PAINFUL SWELLING OF BOTH LEGS, RESEMBLING PHLEGMASIA DOLENS, WITH EXTENSIVE OBSTRUCTION OF BOTH FEMORAL VEINS, IN A PHTHISICAL PATIENT. BY HENY LEE, ESQ.

This woman was seized, while a patient in the Brompton Hospital, with pain, tenderness, and swelling in the upper part of both thighs; the symptoms subsequently extended down the extremities, the legs and feet becoming œdematous. The right limb was the first affected. There were no acute inflammatory symptoms. The affection continued until her death, which occurred about seven weeks after the first appearance of these symptoms. On examination after death, the lungs were found infiltrated with tubercles. The left iliac and femoral veins were completely plugged. The right femoral vein was found to be occupied for eight or nine inches by a continuous false membrane, and obstructed, more or less perfectly, at different parts, by fibrinous deposit. The false membrane was nowhere so adherent to the lining membrane as not to be easily separable from it; and there were portions of the latter over which the false membrane passed which were in no way altered from their natural character. The author proceeded to argue that such a case could not be regarded as having a local origin, and consequently a starting-point from which inflammation might extend, as is stated to be necessary in phlegmasia dolens, and which affection his case accurately simulated in all respects but the absence of any uterine affection; and also to contend that phlebitis may arise independently of any extension of inflammation, and in such instances can only have for its cause the stagnation of the vitiated blood in the vessels. The author quoted a case recorded by Dr. M'Clintock in the *Dublin Quarterly Journal* for August last, in which inflammation of the large veins of the right side of the neck took place in a woman who had a puerperal affection; and detailed several experiments on dogs, instituted for the purpose of proving his arguments.

Dr. Theophilus Thompson bore testimony to the accuracy of the accounts given by Mr. Lee of the case described by him, excepting that the patient had been the subject of phthisical symptoms six years, and not eleven, prior to death. The obstruction of the veins had no relation to the amount of disease of the lungs. In the case in question the amount of tubercular deposit was not great; and there were no cavities of considerable size. There was ulceration of the mucous membrane of the intestines, and also (as in two other cases which he recollected of a somewhat similar nature) some tense-

ness and tenderness of the abdomen—symptoms almost leading one to suspect inflammation of the peritoneum. In a case of a lady, thirty-five years old, one of the most striking symptoms was a marked murmur in the jugular veins—a symptom which he believed to be usually associated with a diminished proportion of fibrine in the blood. None of the cases he had seen were associated with any very decided marks of inflammatory action, and all of them appeared to lead to the conclusion to which Mr. Lee had arrived, that the blood, owing to some peculiarity, more readily absorbed certain morbid elements, and was less able to resist the contaminating influences.

Dr. CURSHAM related the case of a phthisical subject, between thirty and forty years of age, who suffered from œdema of the left leg; and after death there was found an obstruction in the femoral vein, as far as the popliteal. The lungs were extensively diseased on both sides, one lung being completely full of tubercles. The woman had borne children. There was considerable ulceration of the intestines; but no disease of the uterus. He had seen a similar case two years ago—that of a little boy, in whom, after death, there was found an obstruction in the lower part of the vena cava, and in both femoral down to the popliteal veins. There was ulceration of the intestines, but no disease in the pelvic or abdominal viscera.

The PRESIDENT inquired if there was suppuration going on, or whether there was anything in Mr. Lee's case to take it out of the ordinary category of abscesses producing secondary deposits?

Dr. BARCLAY said he had not seen many cases of idiopathic phlebitis, but he had notes of one or two, in which no suppuration was discernible—cases of chlorotic females, in whom there was some derangement of the uterine function.

Dr. PEACOCK had seen cases of obliteration of the renal and portal veins without suppuration, and he thought these were more unexceptionable instances of idiopathic phlebitis (if such a disease existed) than those cases in which suppuration was going on in other parts of the system.

Mr. LEE believed that wherever the blood would stagnate, from whatever cause, phlebitis would be produced. The cases that had been mentioned appeared to confirm the position that inflammation of the veins was not propagated by continuity of surface, but that the disease was carried forward by the blood. The same remark might apply to the arteries: as long as there was a perfect lining membrane there could be no effusion of lymph; but when inflammation was excited in the artery by deposit between its coats, or the coagulation of blood upon the surface, there might be effusion into the arterial canals.

LARGE MYELOID TUMOUR OF THE THUMB. BY T. B. CURLING, ESQ.

M. S., a married woman, aged thirty-two, was admitted into the London Hospital, July 8th, 1856. About twenty years ago, she first noticed an enlargement of the distal end of the metacarpal bone of the right thumb, which gradually increased, without pain, until it attained a great size. About six months since it became painful, and ulcerated in two places, giving exit to a very fœtid discharge. On her admission, the tumour was found to be situated between the thumb and first and second fingers, was irregularly spherical, hollow, and measured six inches in length and five in depth. It was hard and nodulated, consisting, apparently, of a hollow, osseous case. The skin covering it was tense, red, and polished. The tumour implicated the metacarpal bones of the thumb, fore, and middle fingers. At the back of the tumour were two rounded openings, having smooth, bevelled margins, each about the size of a half-crown piece, and communicating with the large cavity in the interior of the tumour, which was lined in some parts by a smooth, laminated membrane, but chiefly by numerous granulations and small excrescences, thickly studded, giving a warty or cauliflower appearance to the part. An abundant fœtid discharge constantly proceeded from the cavity. The woman suffered so much, that although weak and only recently confined, the tumour was removed immediately after her admission. She perfectly recovered. A minute microscopical description of the tumour, made by Dr. Andrew Clark, was given in the paper, and the author called attention to the following characteristics of the case:—the very slow growth of the tumour; its large outgrowth of bone, and hollowness, the latter part being probably due to the degeneration and softening of the solid myeloid elements, and their escape by the ulcerated openings; the combination of an osteoid growth with enchondroma, myeloid disease, and epithelial cancer; the extension of myeloid disease to neighbouring bones by contiguity or encroachment, a circumstance in the history of the disease which, the author believed, had not hitherto been remarked.

SUCCESSFUL REMOVAL OF A LARGE CYST FROM THE UPPER PART OF THE NECK OF A YOUNG WOMAN. BY SAMUEL SOLLY, ESQ., F.R.S.

The patient, a fair, delicate looking young woman, aged 27, who had been considered at birth to be the subject of spina bifida, consulted the author in August last with the object of having a tumour removed. The tumour was hard and unyielding, about the size of a goose's egg, flattened anteriorly; it hung by a broad thick pedicle to the upper part of the neck, a little below the occiput. She suffered no pain, but it was inconvenient from its weight and position. At birth, the tumour was about the size of her head, measuring ten inches and a half transversely at its connexion with the neck, and fourteen inches longitudinally; the lower part was of a dark colour, the skin being very thin, and fluid frequently oozed from that part. It increased for the first three years, but decreased from her third to her sixth year. Until two years of age she was very weak, and her left arm and leg were often much swollen; at this time any movement of the body produced pain. From her second year her health improved, and at four and a half she walked alone. She passed through all the diseases incidental to childhood well up to twelve years of age; at that period she had a fit, preceded by a most violent pain in the head, for which she was bled from the arm, and recovered perfectly; from that time to the present she has enjoyed uninterrupted health. The tumour was seen in early life by several of the most eminent surgeons in town, but nothing was done. Finding that by pressure he could detect no cavity within the tumour; that manipulation gave no pain or inconvenience to the nervous system; having no doubt about the solidity of the pedicle; being able distinctly to feel the arches of the cervical vertebræ underneath it, and being consequently assured that no canal of communication now existed between the tumour and any other part, whatever might have originally been its nature and connexion, Mr. Solly resolved to remove it. The operation was performed on the 25th of August, and the patient is now perfectly well. The hæmorrhage was very free, requiring ligature of six large vessels and other means for restraining it. The wound healed very slowly. There was severe pain in the head at frequent intervals after the operation, but the author considered it hysterical, and it yielded to the use of aconite. A section of the tumour exposed a large cavity in the interior; a saw was required to divide it, in consequence of the walls containing firm calcareous plates. The cyst, which was about equal to two-thirds of the size of the tumour, was lined by a smooth membrane, and contained a viscid yellowish fluid not unlike white of egg; it was completely closed, but the line of junction could be clearly traced by a whitish-yellow line of ligamentous tissue running through the pedicle, which exhibited under the microscope all the characters of the yellow elastic tissue. The firm walls of the tumour were found to be composed of dense fibrous tissue, with calcareous granules interspersed throughout it; these latter consisted of carbonate and phosphate of lime not shaped into bone tissue. The author considered, upon a review of the case subsequently to the operation and the drawing up of his paper, that the tumour, in all probability, originally took its origin from the cranium, and not from the spinal canal. There was no deficiency discoverable in the skull. The patient was now quite recovered, and free from any unpleasant symptoms.

Mr. PRESCOTT HEWETT, who had examined the case, said that when this child was born the occipital bone was lying on the tumour, which afterwards gradually dropped down. He knew of no case of spina bifida where there was so large a tumour about the cervical region. Though it was originally stated, on high authority, that the tumour was spinal, it might not have been meant that it actually came out of the spine; as he had seen, in a museum, a preparation of a reported case of spina bifida, the catalogue stating that the tumour came out of the occipital bone. There was probably, at that period, no accurate notion as to the origin of the tumours, and any tumour occurring about the occipital region might have been referred to spina bifida. In this case the long and slender pedicle came out between the occipital protuberance and the foramen magnum; and the tumour dropping down behind the spinous processes and covering them, the case might, not unnaturally, have been mistaken for spina bifida. In Paris, in 1837, a child having a tumour of a similar character was taken to several hospitals, and the case was pronounced by the

first surgeons to be one of spina bifida, which ought not to be touched. A gentleman, however, performed an operation, and the child died; but the tumour was found to be connected with the occipital region.

Mr. CHAS HAWKINS referred to a tumour in the collection of the Pathological Society, taken from a gentleman who had had it from the period of birth, coming out from the sacrum. The tumour decreased in size at the period of manhood, but the gentleman fell upon it, and death resulted. When first seen it was supposed to be of spinal origin, but in the anterior portion there were found several pieces of bone, resembling the bones of a fœtus, and the supposition was that the tumour was a portion of a twin attached to the patient in the womb, and remaining there during life.

Mr. SOLLY thought the cases were not similar. In the case of imperfectly developed fœtuses, some portions of bone always remained, but in the case he had related there was only a calcareous deposit.

MEDICAL SOCIETY OF LONDON.

SATURDAY, DECEMBER 6TH, 1856.

W. D. CHOWNE, M.D., President, in the Chair.

RECOVERY AFTER SEVERE INJURY OF THE HAND.

BY HENRY HANCOCK, ESQ.

Mr. HANCOCK brought a boy to the society, whose hand had some five weeks previously been drawn in between two pressing rollers of a steam-engine. The space between the rollers through which the hand was drawn was only one-sixth of an inch. When admitted into Charing Cross Hospital, the whole of the phalanges of the four fingers, and the digital halves of the metacarpal bones were found completely crushed and pulverised, the fingers flattened and widened, whilst the index-finger had burst from the pressure. Mr. Hancock, however, as the extent of the wound was comparatively small, determined upon endeavouring to save the hand, and he now submitted the results to the society, drawing attention to the fact that not only were the individual bones restored to their natural shape, but the joints were recovered, and the boy was rapidly obtaining the perfect use of the hand and fingers, an exceedingly good example of conservative surgery.

SOME OF THE PATHOLOGICAL INDICATIONS OF THE URINE.

BY J. L. W. THUDICHUM, M.D.

The author said that the subject which he ventured to bring before the society, though of a practical nature, and closely affecting every case of illness that occurred, yet appeared to many more an ornament than an essential part of medical science, and had been left to operative or analytical chemistry, Clinical medicine, though it recognised as practical features the specific gravity of the urine, the occurrence of deposits and abnormal substances, did, in most cases, not ascertain the bearings in disease of the most important normal ingredients of the urine. It had, in fact, been impossible to ascertain them before the invention of certain analytical methods—the volumetrical method for urea of Professor Liebig, the method of Professor Vogel for determining the amount of colouring matter discharged in the urine, and, above all, before the general introduction of certain principles of observation at the bedside, which, by connecting quantities with time, created a new basis for pathological research. The author's wish was now to bear witness to the practical usefulness and general applicability of these methods and principles. The ease and simplicity of the analysis of urea was connected with so little expense in time, that one might reasonably expect that no practitioner would pronounce upon the quality of any urine without having, by that method, accurately ascertained the amount of urea it contained. The total quantity of urine discharged by healthy adult persons in twenty-four hours the author estimated to vary between 324 and 432 fluid drachms. The variation, or a certain mode of variation, formed an essential symptom of all diseases. Thus the quantity of the urine was diminished in all acute febrile diseases, and the fall and rise or low state of the quantity of urine was pathognomonic of an increase, decrease, or continuance of the intensity of the disorder. The author continued by stating that the amount of the solids discharged by the urine in twenty-four hours had hitherto been under-estimated; for the daily average given by Dr. G. Bird was 650 grains, whereas, by the most accurate observations made with better methods, the mean amount of solids was found to vary between 849 and 1,019 grains. Now, in disease generally the amount of solids sank from the daily 850 or 1,000 grains to 650 or 550 grains, and then was formed mostly at the expense of the body, if little or no food was being taken. The author then considered in detail the pathological indications of the solids in different diseases; explained, by means of a diagram and a scale of colours, the method of Professor Vogel for determining the amount of colouring matter or urohæmatine discharged by the urine, and the pathological indications thereof.

Physiological quantity and pathological indications of urea. Numerous experiments had shown that a healthy man, who lives well, discharges on an average from 463·32 grains to 617·76 grains of urea in twenty-four hours, which, calculated upon one hour, gave 19·3 grains and 25·74 grains respectively. For practical purposes, these figures were valuable, even though subject to certain variations. As urea was the principal product of the metamorphosis in the body of nitrogenized food, the quantity of urea must stand in a direct relation to the quantity of food taken, or, if little or no food be taken, to the amount of nitrogenized component parts of the body disintegrated in the place of food. In this sense must be taken the expression that urea is the measure of dissimilation, if he might be allowed to use this term as the counterpart of assimilation. "Der Harnstoff ist das Maass des Stoffwechsels," says Bischoff; and this was so nearly true, that, with a slight modification of the sentence, we might say, urea is the measure of the most important part of the change of matter in the system. The intensity of the change was expressed by the amount of urea in the urine. More urea was produced during waking than during sleep, more during bodily and mental exertion than during an equal period of inactivity. A large amount of nitrogenized food taken into the stomach would increase the amount of urea above the average; a small amount of vegetable food would make it sink below the ordinary medium. An excess of urea was common in the stadium increments up to and over the acme of all acute febrile diseases, such as typhus, pneumonia, pyæmia, and others; and the total quantity of urea discharged in twenty-four hours might amount to 772 grains, 926, or even 1,235 grains, being double the amount of that discharged during health. This increase was the more an important feature of disease, as the ingestion of nitrogenized matter fell to a minimum at the same time; in other words, because these patients had mostly got no appetite, and if they had, were caused to restrain it by the dietary rules of their medical attendant. As soon, however, as the fever had abated, the amount of urea would sink, and that the lower below the normal quantity the less food the patients were able to take from the loss of appetite continuing, or from the inadequacy of the organs of digestion to perform their task; but as the patients recovered appetite and strength, the amount of urea would rise to its usual height. The same process was observed during the exacerbations of chronic disease, which in fact constituted an acute episode in the long train of symptoms. So an exacerbation of phthisis might be accompanied by a urine similar to that of an attack of pneumonia by containing an excess of urea. But in diseases which were of a chronic nature, and accompanied by impaired nutrition, the amount of urea sank below the average. The lowest amount of urea which the author had ever observed to be discharged during twenty-four hours was 75 grains in 200 fluid drachms of pale, faintly alkaline urine. This was from a lady suffering from an ovarian tumour, for which she had been salivated several years ago. The growth of the tumour had been arrested since that time, but an anæmiated condition of the body had established itself. So low an amount of urea as 75 or 90 grains in twenty-four hours, generally, only occurred towards the fatal end of the disease, when not only was the production of urea very limited, but the excretory activity of the kidneys began to get langnid also. The diminution of the quantity of urea might be due to the failing of the excretory activity of the kidneys only, though at the same time an excess might be produced in the system. The excess was thus retained in the body, and would cause uræmia. In dropsy not connected with disease of the kidney, urea was also retained; but here diuretics might be administered. The amount of urea would here indicate the amount of depuration effected, just as in retention of urea the smaller amount discharged would allow us to calculate, taking the whole case into consideration, the amount produced, and by subtraction the amount retained in the blood. In conclusion, the author performed the quantitative analysis for urea by the volumetrical method of Professor Liebig.

Editor's Letter Box.

POOR-LAW MEDICAL REFORM ASSOCIATION.

LETTER FROM R. GRIFFIN, ESQ.

SIR,—I have addressed a letter to the Right Hon. Viscount Palmerston, with a statement of the grievances of the Poor-law officers, and remarks on sanitary measures and vaccination. A copy is now in the press, and will shortly appear in the form of a pamphlet, for distribution to each member of Parliament and Poor-law medical officer.

I beg to lay before your readers the annexed correspondence between Mr. Fox and the Romsey guardians, which speaks for itself. I can only add, that I hope no gentlemen (especially a colleague, as in the case of the late vacancy in the Frome Union) will be found to accept the appointment, and thus verify the words of the Poor-Law Board, that "whenever a vacancy occurs, there are plenty of candidates for the office, and therefore there is no need of increasing the salaries."

Let the profession be true to itself, and the guardians will be compelled to do Mr. Fox justice by re-appointing him at an increased salary, which undoubtedly he merits, or they surely would not have permitted him to hold the office during the last twenty years. I am, etc., RICHARD GRIFFIN.

12, Royal Terrace, Weymouth, January 5th, 1857.

I. *Mr. L. O. Fox to the Board of Guardians of the Romsey Union.*

"December 20th, 1856.

"GENTLEMEN,—I beg respectfully to state that, as the price of articles consumed in conducting a union practice, viz., corn, hay, and horseflesh (not to mention double income tax), has advanced, I am compelled to apply for an increase of salary. I would remind the Board that my present stipend is only 13*s.* 10*d.* per week for attendance on the sick paupers in a population of 1,400, over an area of 5,000 acres—a sum quite inadequate to the duties required.

"I am, etc., L. OWEN FOX."

II. *Copy of Proceedings of the Board of Guardians.*

"Romsey Union, December 29th, 1856.

"The application of Mr. Fox, medical officer, for an increase of salary, for reasons stated in his application, was considered, and it was moved, and resolved unanimously—

"That, at the special meeting held this day, the Board declined to augment the salary of Mr. Fox; but, in case Mr. Fox should be dissatisfied with the present rate of payment, the Board will be happy to receive his resignation.

"Ordered that the clerk do forward a copy of this minute and resolution to Mr. Fox."

III. *Mr. Fox to the Board of Guardians.*

"December 31st, 1856.

"GENTLEMEN,—I beg to inform you that I cannot continue my services as medical officer on the present terms, and therefore give you notice that, on and after 26th January next, I shall resign my appointment.

"I am, etc., L. OWEN FOX."

MEDICAL ETIQUETTE.

LETTER FROM J. R. HUMPHREYS, ESQ.

SIR,—The letter which you published last week from Mr. A. G. Field is an apt illustration of the old adage, "There are none so blind as those who won't see." Your correspondent seems to throw a doubt on the statements which I made in the JOURNAL of the 13th December, as to whether Mr. Long did or did not consult with the homœopath. Now, sir, I beg to inform your correspondent, that Mr. Long not only consulted with the homœopath, but approved of what he had done; and Mr. Long met the homœopath on two or three occasions. Mr. Field objects to my suppositions being taken as facts: the only supposition I advanced was, that Mr. Long took his fee; and I think that is a very reasonable supposition for me to make, as I do not suppose Mr. Long would come from Liverpool without his fee, to meet a homœopath whom no one in Shrewsbury would meet in consultation. Your correspondent thinks that by answering to the summons of a patient who is attended by a homœopath, "he does not sacrifice the honour or dignity of his calling." Now, with all respect to his judgment, I think he does. He draws the line between right and wrong so faintly, that he cannot well keep on the right side of it. I think it would be far more consistent with his dignity if he—and all others who possess similar latitudinarian principles—would not pander to the caprices of their patients by meeting those who, according to Mr. Field's own admission, are practising a delusion. Your correspondent says, "as a body we have no place till each one gains it by his individual character and excellence." To a certain extent this is true; but I would remind him that he has a duty to perform to his profession as well as to himself; and that is, he ought not to sanction by advice or counsel those whom our profession as a body has clearly and unmistakably announced to be none of us.

I enclose you a copy of a letter which appeared in one of our town newspapers. It will, I hope, satisfy even Mr. Field's scruples with respect to the statement I made in my former letter. I am, etc.,

J. R. HUMPHREYS.

Shrewsbury, Jan. 6th, 1857.

[COPY.]

To the Editor of the Shrewsbury Chronicle.

SIR,—As it appears some misconception prevails with regard to the causes of the decease of the late lamented Mr. Corbet of Sundorne, in consequence of one of his medical attendants being a homœopathist, I am desired by the family to state, for the satisfaction of his friends, and as a simple act of justice to Dr. Wilkin:—1st. That Mr. Long, the eminent surgeon of Liverpool, who was called in at an early period, was satisfied that everything had been done that could be done, to avert the fatal issue—an opinion which was afterwards fully confirmed by Mr. Fergusson of London. 2nd. That both these eminent men were convinced from the character which the malady assumed in its last stages, that the case had been beyond human aid for a very considerable time previous to the development of the symptoms which first induced the lamented deceased to call in the aid of Dr. Wilkin.

I am, Sir, your obedient Servant, B.

Sundorne, Dec. 6th, 1856.

DOUBLE OPERATION FOR CATARACT.

LETTER FROM EDWIN CHESSHIRE, ESQ.

SIR,—I find, in an article by Mr. J. V. Solomon, published in the ASSOCIATION JOURNAL for December 27th, 1856, the following passages:—"The traditional practice of the Birmingham Eye Infirmary, which was founded in 1823 by Mr. Hodgson, has been to extract hard cataracts, the pupils having been previously dilated; to delay the operation till the patient is quite blind, or nearly so; and to remove both cataracts on the same day, while the patient is in the recumbent posture; the upper section of the cornea being performed in the right eye, and the lower in the left. . . . . A cataract having been extracted, the surgeon at once directs his attention to the means that are likely to obtain an early union of the wound. In furtherance of this end, I esteem it of importance that the upper section should have been made in the left eye as well as in the right. I have succeeded in accomplishing this upon patients whose eyes are not prominent relatively to the brow, and in some who experienced a difficulty, through nervousness or other causes, in looking downwards at the time of the operation."

I beg to say that it is, and *always* has been, the practice of my colleague Mr. Townsend and myself to perform the upper section of the cornea in *both* eyes, when operating by extraction for double lenticular cataract, whenever the nature of the case has permitted such a proceeding. I would also further state, that it was my invariable custom to perform the upper section in *both* eyes long before Mr. Solomon was connected with the Eye Institution; and, if I am not mistaken, similar operations were performed by Mr. Hodgson and Mr. Middlemore. It certainly is the practice of the Birmingham Eye Infirmary to extract both cataracts at the same operation; and the result having been so satisfactory, I see no necessity for putting the patient, who usually can ill afford the time, to the annoyance and inconvenience of a second operation, and the confinement to the house consequent thereon. I fully agree with Mr. Solomon in the propriety of removing a single cataract, whether traumatic or otherwise, *when dislocated, and producing by its pressure and displacement very severe pain and irritation.*

I am, etc., EDWIN CHESSHIRE,

Senior Surgeon to the Birmingham and Midland Eye Institution.

Birmingham, January 2nd, 1857.

Medical News.

BIRTHS, MARRIAGES, DEATHS, AND APPOINTMENTS.

** In these lists, an asterisk is prefixed to the names of Members of the Association.*

BIRTHS.

ALLAN, John, M.D., of Milner Square, Islington, the wife of—a daughter—on January 1st.

ALLNATT, R. H., M.D., of Pensarn, Denbighshire, the wife of—a son, who survived only two days—on December 29th, 1856.

CLARKE, John, M.D., of Hertford Street, May Fair, the wife of—a son—on January 1st.

COCKELL, Frederick E., Esq., Surgeon, of Upper Bath Place, Dalston Green, the wife of—a daughter—on January 2nd.

HUXLEY, Thomas H., Esq., F.R.S., the wife of—a son—on December 31st, 1856.

JEAFFRESON, Henry, M.D., of Finsbury Square, the wife of—a son—on January 5th.

OGILVIE, J. F., M.D., the wife of—a son—at Alexandria, Egypt, on December 15th, 1856.

PEREGRINE, Thomas, M.D., of Half Moon Street, Piccadilly, the wife of—a daughter—on December 26th, 1856.

*SINCLAIR, D., M.D., of the Terrace, Camberwell, the wife of—a daughter, stillborn—on December 31st, 1856.

*SPENCE, Wm., M.D., Letham, Ladybank, Fife, the wife of—a son—on December 31st, 1856.

STEVENS, Charles Palmer, Esq., Surgeon, of Biggleswade, Bedfordshire, the wife of—a son—on December 29th, 1856.

*STONE, Robert N., Esq., Surgeon, of Bath, the wife of—a son—on January 4th.

WHATELY, Edward, Esq., Surgeon, of Brighton, the wife of—a son, on December 30th, 1856.

MARRIAGES.

COLLIER—HARRIS. COLLIER, Thomas Poole, Esq., Surgeon, of Worship Street, Finsbury, to Sarah Ann, eldest daughter of Lawrence Beeton Harris, Esq., of Mile End Green, at St. Dunstan's, Stepney, on January 3.

ELLISON—BLYTHMAN. ELLISON, Henry, Esq., of Stone, near Tickhill, to Emily Frances, eldest daughter of *Robert Otter Blythman, Esq., Surgeon, of Swinton, Yorkshire, at Swinton, on December 31, 1856.

HALL—NEATHERWAY. HALL, John, Esq., Surgeon, of Caroline Place, Haverstock Hill, to Miss Neatherway, of Stratford Place, Camden Town, at St. Pancras Church, on December 30, 1856.

JOHNSTON—ACLAND. JOHNSTON, Alexander, Esq., Surgeon, of Wanganui, New Zealand, to Emily Harriette, only daughter of the late Rev. Charles Acland, Chaplain H.E.I.C.S., at St. Paul's Cathedral, Auckland, New Zealand, on September 2, 1856.

LEE—BLUETT. LEE, A. C., Esq., Medical Officer Bengal Marines, to Margaret, widow of the late J. R. Bluett, Esq., R.N., at Calcutta, on October 30, 1856.

LE TALL—BOWER. LE TALL, Benjamin, Esq., of Handsworth Woodhouse, Sheffield, to Susannah Bower, of Cartwright Street, Doncaster, at the Friends' Meeting House, Doncaster, on December 31.

MACADAM—CLARK. MACADAM, John, M.D., of Melbourne, Australia, to Elizabeth, second daughter of John Clark, Esq., of Levenfield House, Dumbartonshire, at Melbourne, on September 18, 1856.

MACREIGHT—LAX. MACREIGHT, W. W., M.D., to Frances Mary, widow of the late John LAX, Esq., of Knap Hill, Somerset, at Horrington Church, on January 1.

WEBBER—ROSS. WEBBER, the Rev. Richard L., to Henrietta Porter, youngest daughter of the late John Ross, M.D., of St. Croix, at the Cathedral, George Town, Demerara, on December 2, 1856.

DEATHS.

DRIVER, Thomas, M.D., H.E.I.C.S., in Sauchiehall Street, Glasgow, on January 1st.

HENDERSON, Thomas, Esq., late a student at St. George's Hospital, of scarlet fever, contracted while performing, *pro tempore*, the duties of House Surgeon to the Hospital for Sick Children, at 8, Devonshire Street, Portland Place, aged 23, on January 3rd.

URE, Andrew, M.D., F.R.S., at Upper Seymour Street, Portman Square, on January 2nd. Dr. Ure was born in Glasgow, on May 18th, 1778. After studying in the University of Glasgow, and subsequently in that of Edinburgh, he became a graduate of the Glasgow University in 1801, having previously taken the degree of Master in Arts. He became a Member of the Faculty of Physicians and Surgeons in Glasgow in 1803, and was appointed Andersonian Professor of Chemistry in the University of that name in Glasgow, where he also delivered systematic courses on Materia Medica. In 1809, preparatory to establishing the Observatory in Glasgow, he went to London, where he met and acquired the friendship of Maskelyne, Pond, Groombridge, and other astronomers, as well as of Sir H. Davy, Wollaston, Henry, and the other distinguished chemists of that period. He held the Scientific Observatory at Glasgow for several years, and was there visited by Sir W. Herschel on friendly terms. In 1813, he published at Glasgow *A Systematic Table of the Materia Medica*, with a preliminary dissertation on the operation of medicines. In 1818, he published an interesting memoir, entitled *New Experimental Researches on some of the Leading Doctrines of Caloric, particularly on the relation between the Elasticity, Temperature, and Latent Heat, of different Vapours, and on Thermometric Admeasurement and Capacity.* The conclusions offered in this remarkable paper have been adopted by Mr. Ivory, Mr. Daniell, and other philosophers, as the basis of their meteorological theories. In 1818, he published *Experiments on Nitric Acid;* as well as essays *On a New Explosive Eudiometer*, and on *The Relation between Muriatic Acid and Chlorine.* In 1819, he gave an account of some galvanic experiments made on the body of a recently executed criminal; and wrote *On the Constitution of Muriatic Acid of different gravities.* In 1821, the *Dictionary of Chemistry* was first published. In 1822, he published the *Ultimate Analysis of Vegetable and Animal Substances*, to which the term organic chemistry is now applied. In 1824, he published a translation of *Berthollet on Dyeing and Bleaching.* In 1829, he published his new *System of Geology.* In 1830, some *Observations on Indigo.* In May 1830, he came to London, and became Chemist to the Board of Customs, and conducted important researches on sugar for the Government. In 1833, the House of Commons published a report, entitled *Researches on Sugar Refining, instituted at the desire of the Lords of the Committee of the Privy Council;* these important researches of Dr. Ure led to the fixation of the then established duties by Government. In 1834, an *Analysis of the Moira Brine Spring, with Researches on the Extraction of Bromine*, was published by Dr. Ure in the *Philosophical Transactions.* In 1835, he published the *Philosophy of Manufactures.* In 1836, he published *The Cotton Manufacture of Great Britain, compared with that of other Countries.* In 1837, he published his large work on the *Arts and Manufactures*, with a supplement about two years later; the whole of which has been since greatly enlarged in the last edition of 1853. Mr. Fairbairn, whose opinion is entitled to due consideration, asserts that any person might easily make the machines requisite for that branch of manufacture from a perusal of Dr. Ure's book on the subject of cotton, a sufficient proof of the accuracy of the descriptions and drawings therein contained. Though he had been in delicate health for some years past, he was not seriously indisposed until within a short period of his decease, which occurred somewhat unexpectedly on the morning of the 2nd inst. Dr. Ure was elected a Fellow of the Royal Society in 1822; he was a Fellow of the Geological Society from its foundation; of the Astronomical Society for many years; and also of many learned foreign societies. From looking over his principal writings, it will be seen that every department of chemical science has in succession been made the subject of a distinct investigation. The following testimony to his talents as a lecturer, has been borne by the eminent botanist, Sir W. J. Hooker:—"He has a great and judicious command of language; his delivery is clear, and animated, and forcible; he displays a most thorough knowledge of the subject on which he treats, whether in chemistry or natural philosophy; and he illustrates that subject by the most successful experiments." Dr. Ure was distinguished as a profound chemical philosopher, and also for remarkable skill and exactness in chemical analysis. It has been indeed asserted, on competent authority, that none of his results have ever been upset.

WIBLIN, William, Esq., Surgeon, late of Strood, Kent, at Alfred Street, Bedford Square, aged 40, on December 31st, 1856.

[ERRATUM. In the obituary of last week's number, for "WARD, William, Esq., Surgeon, at Forant, near Shrewsbury", read "WEBB, Wm., Esq., Surgeon, of Llangollen, Denbighshire".]

APPOINTMENTS.

HOOKER, Sir William, elected a Corresponding Member in the Botanical Section in the Academy of Sciences in Paris.

MAYO, Thomas, M.D., elected President of the Royal College of Physicians of London.

ROGERS, W. R., M.D., elected Physician to the Farringdon Dispensary and Lying-in Charity, in the room of Dr. Ballard, resigned.

HEALTH OF LONDON:—WEEK ENDING JANUARY 3RD, 1857.

[From the Registrar-General's Report.]

IN the week that ended on Saturday, the deaths of 1,497 persons, viz., 761 males and 736 females, were registered in London. In the first week of the year, during the period 1847-56, the average number of deaths was 1,321; and if this is raised in proportion to increase of population, for comparison with the number in the present return, it becomes 1,453. The deaths now recorded exhibit an excess of 44 over the corrected average.

The number of deaths registered last week is augmented to a very considerable extent by deaths, in reference to which inquests had been held, having been entered in the register-books in more than their just weekly proportion. Many of such cases were not registered till the end of the quarter, though they had occurred, and been investigated by the coroner, at earlier dates. For 25 deaths were referred last week to burns and scalds, 16 to hanging and suffocation, 29 to drowning, 48 to fractures, 7 to wounds; 45 deaths were returned of persons "found dead," or who died suddenly from an unknown or unstated cause. Under these heads and a few others the excess will chiefly be found.

Hooping-cough appears to have been more fatal last week than any other disease in the zymotic class; 51 children died of it. Measles was fatal in 38 cases, typhus and common fever in 37, scarlatina in 29, small-pox in 5. Measles prevails chiefly in the North districts, Marylebone, Camden Town, Islington. Six children died of it in the sub-district of Islington West. A family is mentioned by the Registrar of Hackney-road, in which four children have been attacked by scarlatina maligna, and two have died. A seaman died on the 20th December, from "want of sufficient nourishment," and a widow on the 28th, "apparently from destitution."

The deaths of 8 persons were registered last week, who had attained the age of 90 years or upwards. A man who had been a butler, was the oldest, and died at the age of 94 years.

Last week the births of 1,025 boys and 948 girls, in all 1,973 children, were registered in London. In the ten corresponding weeks of the years 1847-56 the average number was 1,598.

At the Royal Observatory, Greenwich, the mean height of the barometer in the week was 29·746 in. The mean daily reading was above 30 in. on Tuesday and Wednesday. The highest reading was 30·13 in. on Wednesday, and the lowest 28·97 in. on Saturday. The mean temperature of the week was 40·6°, which is 3·7° above the average of the same week in 43 years (as determined by Mr. Glaisher). The mean temperature was 11·3° below the average on Sunday, and was as much above it on Thursday. The lowest temperature on Sunday was 18·5°, and on the following Thursday it was 44·5°. The highest temperature occurred on Friday, and was 52·7°, and the range of the week was 34·2°. The mean dew-point temperature was 37·1°, and the difference between this and the mean air temperature was 3·5°. The mean temperature of the water of the Thames was 39°. The temperature of the river ranged from 36·9° to 41·5°. The direction of the wind was generally west-south-west. The horizontal movement of the air on Saturday was 410 miles. A very heavy gale of wind blew on the evening of that day, accompanied with frequent showers. Between 7 and 10 o'clock P.M. the pressure of wind on the square foot varied from 10 to 12 lbs. The amount of rain in the week was 0·23 in., which fell on three days.

A VERY AWKWARD SITUATION. An accident which, though comic enough, might easily have had a tragical ending, occurred the other day at Madame Tussaud's Exhibition. A medical student, examining the guillotine in the Chamber of Horrors, took it into his head that the sort of yoke which fits down on the shoulders of the criminal to hold him in his place would not be sufficient to confine a person who struggled. His curiosity on this point led him to watch till the place was empty, when he actually put himself in, letting down the yoke. He soon found that he was quite unable to lift it, and it at once flashed into his mind that the sharp axe which was suspended over his neck could not be very firmly fixed, or it would not fall (as it does) with a touch. He was afraid to struggle, lest the shaking should bring it down and at once deposit his head in the basket of sawdust below him, into which his eyes were of necessity steadily looking. Having stayed some time in this plight, he was overjoyed to hear the approach of a visitor, whom he implored to release him. "I'm thinking," said the gentleman (a Scotch visitor of the metropolis) to his wife, "I'm thinking he must be hired to show how the thing acts, and I think we'd better not interfere." So the luckless student was left till M. Tussaud came in, and made fast the axe before releasing him. The axe has been removed and laid by the side, to prevent future accidents. (*Weekly Register.*)

THE LATE DR. PARIS. On Wednesday week last the mortal remains of Dr. Paris were conveyed by railway to the Necropolis Cemetery at Woking Common for interment. The funeral was of a strictly private and unostentatious character, and was attended only by the members of his own family, with the exception of Mr. Justice Cresswell, who is one of the executors of the deceased.

MILITIA SURGEONS. The *Dublin Evening Mail* states that it is intended shortly to employ surgeons of the militia in recruiting for the line regiments, and other duties connected with the service, so as to relieve, to a certain extent, the regimental surgeons, thereby enabling these latter to pay greater attention to the sick of their respective corps, and also to attend more closely to the hospital department with which they are connected.

ROYAL MEDICAL BENEVOLENT COLLEGE.

The following document, being the second Report of the Committee appointed to ascertain the amount to be charged to the Exhibitioners, has been forwarded to us for publication.

"*To the Council of the Royal Benevolent College.*

"GENTLEMEN,—Your Committee, having been requested to re-consider their Report as to the amount to be charged annually to each Exhibitioner, beg to submit to the Council the result of their second investigation, by which it will be seen that no diminution in the present annual charge of £40 can be made.

"In prosecuting this investigation, your Committee have been guided in all instances by the actual amounts of the various disbursements on account of the School; to ascertain which they have examined every item of expenditure contained in the several accounts for the current year, and gone carefully through the books of the Institution, assisted by your Secretary.

"In this calculation, they have not included any portion of the original outlay expended in the foundation of the Institution, the purchase and inclosure of the Land, the cost of the erection of the Building, or of the Chapel.

"Your Committee refer the Council to the accompanying statement, according to which the actual present cost of each Exhibitioner is £38 : 16 : 2; but this calculation does not include any expenses for repairs of fabric, or painting, for keeping up the grounds (of which the Exhibitioners have the benefit), for the annual expenses connected with the chapel, for additional masters (of which one for German will very shortly be required), for extra Servants (which are stated by the Visiting Committee to be necessary), or for any such incidental expenditure as is inseparably attendant on an Institution of this nature.

"To meet these inevitable disbursements, your Committee recommend that the sum of £1 : 3 : 10 be added to the above amount of £38 : 16 : 2, making the charge to each Exhibitioner £40 per annum.

"We have the honour to be, Gentlemen,
"Your obedient Servants,
"FRANCIS WEBB, *Chairman.*
"HENRY HANCOCK.
"CHARLES HOGG.

"37, Soho Square, London, Dec. 22, 1856."

ABSTRACT OF STATEMENT REFERRED TO IN REPORT.

Amount of Outlay for the use of the School exclusively.

	£	s.	d.
Fittings in dormitories, school and class rooms, offices, etc.	1354	0	0
New works, viz., iron hurdles, cap boxes, play-ground	543	0	0
Gas fittings, hot water apparatus	375	0	0
Sundries, viz., lifts, baths, and lavatories	419	0	0
Cost of furniture	2980	0	0
	£5621	0	0

Annual Expenditure.

Salaries and wages (school)	1451	10	0
School implements, books, etc., at 30s. a head for 150 boys	225	0	0
Board for 150 boys and 19 masters and servants	2232	18	3
Washing for 150 boys and 15 servants	335	16	10
Medical attendance	47	2	0
Miscellaneous disbursements: coals, wood, gas, water, as per contract, poor rates, taxes, etc., insurance on school furniture and fittings for £3000, at 4s. 6d. per cent.	578	3	9
Office expenses, viz., salaries (share), rent of office £83 (half), printing and stationery, postage and carriage of parcels	238	10	0
Linen, at £1 per head	150	0	0
Wear and tear on outlay for exclusive use of the school, on £5621 at 10 per cent.	562	2	0
	£5821	2	10

The above £5821 : 2 : 10 annual expenditure, divided by 150 boys, gives as the actual cost of each boy the sum of £38 : 16 : 2. But of these 150 boys, four, viz., the Surrey scholars, pay only £15 a year. Therefore to meet the above annual expenditure,

Say 146 boys at £40	£5840	0	0		
4 boys at £15	60	0	0		
10 day boys at £12	120	0	0		
				6020	0 0
Deduct annual expenditure as above				5821	2 10
Balance				£ 198	17 2

FRANCIS WEBB, *Chairman.*
HENRY HANCOCK. CHARLES HOGG.

MEDICAL SOCIETY OF LONDON. A paper will be read at 8 P.M. on Saturday, January 10th, by Dr. Snow, "On the Vapour of Amylene".

ASSOCIATION OF MEDICAL OFFICERS OF HEALTH. The ordinary meeting of the Association will be held at the General Board of Health on Wednesday, January 14th, at 4 P.M.

TO CORRESPONDENTS.

LETTERS and other COMMUNICATIONS for the JOURNAL should be directed to the private address of the Editor, 39, Curzon Street, May Fair.

Members should remember that corrections for the current week's JOURNAL should not arrive later than Wednesday.

To CONTRIBUTORS. The Editor would feel glad if Members of the Association and others, would cooperate with him in establishing as a rule, that in future no paper for publication shall exceed two pages of the Journal in length. If the writers of long communications knew as well as the Editor does, that lengthy papers *always* deter the reader from commencing them, this great evil would never arise. Brevity is the soul of medical writing—still more than of wit.

ADMISSION OF NEW MEMBERS. Several associates have addressed inquiries to us regarding the mode of admitting Members to the BRITISH MEDICAL ASSOCIATION. The laws of the Association state that any member of the profession not disqualified by any bye-law (that is, any respectable member of the profession) may be admitted at any time by the Committee of Council, or by the Council of any Branch, on being proposed by *three* Members. Associates desirous of proposing new Members, should forward the names at once, either to the Branch Secretary of the district in which they reside, or to the General Secretary, Dr. P. H. WILLIAMS, Worcester.

MR. PEARSON, of Buxton, requests us to state, that in the Volume for 1857 of *the London and Provincial Medical Directory*, there is an error in the return attached to his name. He is not *Consulting* Surgeon, but *Surgeon* to the Charity.

AN ASSOCIATE. We have seen the very unwarrantable attack upon ourselves in the preface to Mr. Lara's new Medical List, and shall not fail to answer it when we notice the Medical Directories next week.

We have received from Mr. E. STEVENS, of Cambridge Road, two loaves of bread, as specimens of the pure and unadulterated staff of life, being made of flour, yeast, spring water, and a small quantity of salt only. We can safely affirm that this bread tastes remarkably wholesome; but, as we have not analysed it, we cannot say anything as to its constituents. We rejoice to find that the late inquiry into the adulterations of articles of food has at length attracted the attention of intelligent vendors of food, such as Mr. Stevens.

We are obliged to Mr. Wilde for the manner in which he speaks of the article in question. We have received "Saunders's Dublin News-Letter."

Communications have been received from:—MR. R. WOOD; MR. THOMAS B. HORNE; MR. C. H. ROPER; MR. J. R. HUMPHREYS; DR. J. L. W. THUDICHUM; MR. FREDERICK H. HARTSHORNE; DR. J. B. PITT; MR. ALEXANDER URE; DR. BELL FLETCHER; MR. RICHARD GRIFFIN; MR. J. BURROWS; MR. I. HARRINSON; MR. W. H. MICHAEL; MR. J. ARMITAGE PEARSON; MR. HENRY EWEN; DR. LYON; MR. EDWIN CHESSHIRE; MR. W. T. BELL; MR. W. H. JOHNSON; MR. W. A. RACKHAM; MR. JOHN JONES; DR. EDWARD SMITH; MR. J. V. SOLOMON; DR. G. G. ROGERS; MR. J. K. SPENDER; MR. THOMAS O'CONNOR; DR. BRITTAN; MR. J. I. IKIN; DR. S. JEAFFRESON; DR. P. H. WILLIAMS; DR. HAYES JACKSON; DR. THOMAS HILLIER; MR. MCDERMOT; MR. GEORGE MAY, JUN.; and DR. KING CHAMBERS.

BOOKS RECEIVED.

[* *An Asterisk is prefixed to the names of Members of the Association.*]

1. The Medical List for 1857, or English Medical Directory. London: Lane & Lara.
2. The London and Provincial Medical Directory for 1857. London: Churchill.

ADVERTISEMENTS.

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Tables for the Microscopical and CHEMICAL EXAMINATION OF URINE, URINARY DEPOSITS, AND CALCULI. By DR. LIONEL BEALE, Physician to King's College Hospital, Professor of Physiology and Morbid Anatomy in the College.
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